STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215316	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Baltimore Washington	313 Hospital Drive Glen Burnie, MD 21061

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** 18819 Based on reviews of a complaint and a medical record, and interviews with facility staff, it was determined that the facility failed to notify the resident's physician regarding the incorrect documentation of a Resident's weight. This was evident for 1 (Resident #6) of 8 residents reviewed during a complaint survey. The findings include: Review of complaint MD00201378 on 04/28/25 revealed an allegation Resident #6 is not receiving care and services to heal a sacral wound. Review of Resident #6's clinical record on 04/28/25 revealed Resident #6 was admitted to the facility on [DATE] with diagnoses that include: quadriplegia, recent placement of a gastrostomy tube on 02/19/25, a sacral pressure ulcer, malnutrition, and contractures of the right and left ankles. On 02/20/25 the nursing staff obtained a readmission mechanical lift weight of 113.8 pounds for Resident #6. On 02/26/25 at 7:01 AM, the nursing staff obtained a mechanical lift weight of 119.4 pounds for Resident #6. Review of Resident #6's care plans revealed a nursing care plan to address Resident #6's being a nutritional risk, malnourished, having a history of weight loss, and having a sacral wound. This nutritional risk care plan was initiated on 02/21/25. The goal of the care plan was for Resident #6 to gain safely weight over the next quarter to a desired weight of 125 pounds with a daily meal intake of 75-100% of each meal. Nursing interventions included: 1) To administer the physician prescribed diet as ordered. 2) If Resident #6 consumes less than 50% of a meal, notify the nurse and provide a bolus delivery of tube feeding. 3) To monitor Resident #6's weights, labs, and intake 4) Notify Resident #6's physician and dietician if resident has any significant weight loss. 5) administer supplements as ordered. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #6's medical record revealed an attending physician assessment note, dated 03/04/25 in which Resident #6's physician noted the 02/26/25 documented weight of 119.4 pounds on Resident #6 and indicated: Patient (Resident #6) is now gaining weight. Further review of Resident #6's medical record revealed that on 03/11/25 at 10:40 PM, the facility director of nurses (DON) struck out Resident #6's, 02/26/25 weight of 119.4 pounds and indicated this was incorrect documentation. The facility staff documented a weight of 119.4 pounds for Resident #6 on 02/26/25. The nursing staff obtained a weight of 112.8 pounds on 03/11/25. The weight difference between the 02/26/25 weight of 119.4 pounds and the 03/11/25 weight of 112.8 pounds is a weight loss of 6.6 pounds (5.5%). This significant weight loss occurred in a 3-week period for Resident #6 (02/19/25 through 03/11/25). In an interview with the facility DON on 05/01/25 at 11:50 AM, the facility DON stated that s/he struck out Resident #6's 02/26/25 weight of 119.4 pounds on 03/11/25 because the weight of 119.4 pounds was to be recorded in another resident's medical record. The DON stated that s/he did not notify Resident #6's physician at the time the weight of 119.4 pounds noted to be a mistaken entry on 03/11/25. After 02/26/25, the facility staff documented the following weights for Resident #6: 03/05/25 - 114.8 pounds by mechanical lift. 03/11/25 - 112.8 pounds by mechanical lift. 03/20/25 - 113.2 pounds by mechanical lift. 04/04/25 - 113.0 pounds by wheelchair scale.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on complaint, observations of a resident's wound care, and staff interview, it was determined that the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This was observed for 1 (Resident #6) of 8 complaints reviewed during a complaint survey. The findings include: Review of complaint MD00201378 on 04/30/25 revealed an allegation that the facility was malodorous and unkept. During an observation of Resident #6's wound care dressing change in room [ROOM NUMBER]-A, on 05/02/25 at 10:45 AM, the nurse surveyor observed the following: 1) The privacy curtain was in disrepair and hanging on the floor and could not completely give Resident #6 privacy during care. 2) The bedside table was in disrepair and 2 of the 3 drawers were observed to be in disrepair and would not close. 3) The closet door was observed in disrepair and would not close completely. After the staff completed Resident #6's dressing change on 05/02/25 at 10:45 AM, an interview with the facility director of nurses (DON) s/he was immediately made aware of the observations in Resident #6's room. The DON acknowledged that the furniture appeared to be in disrepair and notified the maintenance director to address the items in disrepair in Resident #6's room.

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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. 18819 Based on complaint, reviews of clinical records and all pertinent administrative records, reviews of a hospital record, and staff interview, it was determined that the facility staff failed to immediately report an allegation of suspected resident abuse to the administrator and the State Survey Agency within 2 hours. This was evident for 1 (Resident #4) of 8 residents reviewed during a complaint survey. The findings include: Review of complaint MD00212137 on 04/21/2025 at 10 AM revealed an allegation that Resident #4 was hurt by a facility staff member while being lifted in a Hoyer (mechanical) lift because Resident #4 was not secured correctly in the Hoyer lift. In an interview with the facility Director of Nurses (DON) on 04/23/25 at 11:35 AM, the DON stated that there were allegations of abuse, facility reported incidents, or complaints regarding Resident #4. The DON stated that S/he would look in the administrative forms for a completed grievance form regarding Resident #4. Review of Resident #4's physical therapy progress notes on 04/25/25 revealed a physical therapy assistant (PTA#1) progress notes dated Monday, 10/21/24 at 3:53 PM that indicated Resident #4 was complaining of soreness in the right hip after an incident with Hoyer lift from Friday 10/18/24. A review of PTA#1's 10/23/24 progress note revealed that Resident #4 again complained of soreness in the right hip after being weighed on 10/22/24 while in bed. RTA#1 documented that Resident #4 complained of being hurt by the aides (geriatric nursing assistants) and not being able to get out of bed into a wheelchair. Resident #4 refused assistance by RTA#1 to help to get into the wheelchair and participate in group therapy. In an interview with PTA#1 on 04/25/24 at 12:24 PM, along with the Director of Therapy and the facility Director of Nurses, PTA#1 stated that Resident #4 complained of pain the first time PTA#1 seeing Resident #4 on 10/21/24. On 10/23/24, PTA#1 stated seeing Resident #4 for physical therapy. PTA#1 indicated that Resident #4 stated that S/he felt like the aides hurt him/her. RTA#1 stated that Resident #4 was not asked to elaborate how the staff hurt him. RTA#1 stated that S/he informed the Director of Therapy about Resident #4's allegation of being hurt be staff. RTA#1 stated that S/he did not notify any other facility administrative staff of Resident #4's allegation of being hurt by staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN#5, a nursing unit manager, on 04/23/25 at 12:41 PM, RN#5 stated that S/he received a concern form from Resident #4 on 10/25/24. RN#5 stated that S/he addressed Resident #4's concerns on 10/26/24. RN#5 documented the following nursing actions that were implemented on 10/26/24 regarding Resident #4: 1) Resident asked to a physician on 10/21/24. The nurse practitioner went in and saw Resident #4 and answered all questions, 2) Resident #4 complained of heartburn. The nurse practitioner ordered the medication, Tums, orally every 6 hours as needed, 3) Unit manager spoke with the staff and asked the staff to be more gentle/cautious with Resident #4's lower extremities, 4) Unit manager met with Resident #4 and asked him/her to use the call bell for assistance when transferring, to be patient if the aides/nurses are with other residents and it could take a few minutes before staff to come in and assist. Educated Resident #4 on waiting for assistance due to being assessed as a high fall risk. Resident #4 verbalized understanding. RN#5 was asked to provide the staff sign in sheets that demonstrated what nursing staff had received the education regarding Resident #4. RN#5 stated that there are no records of what education or the staff that received the education regarding Resident #4 from 10/26/24. Further review of Resident #4's closed medical record failed to reveal Resident #4 received a dose of Tums between 10/21/24 and 10/26/24. Further review of Resident #4 closed medical record revealed a 10/26/24, 10:48 AM nursing progress that indicated Resident #4 requested to go to the emergency room . The nurse contacted the on-call nurse practitioner and was given instructions that it was okay for Resident #4 to dial 911. A review of Resident #4's 10/26/24 hospital record revealed Resident #4 arrived at the emergency room at 12:55 PM by 911 ambulance with a chief complaint of heartburn and chest pain and requested not to be returned to the nursing facility. Resident #4 was admitted to the hospital with diagnoses that included: Atypical chest pain, ambulatory dysfunction, and neglect of an adult.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 18819 Based on medical record review, facility investigation review, and staff interview, it was determined that the facility failed to thoroughly investigate a resident's allegation of being physically injured by nursing staff members. This was evident for 1 (Resident #4) of 8 residents reviewed during the complaint survey. The findings include: Review of complaint MD00212137 on 04/21/2025 at 10 AM revealed an allegation that Resident #4 was hurt by a facility staff member while being lifted in a Hoyer (mechanical) lift because Resident #4 was not secured correctly in the Hoyer lift. In an interview with the facility Director of Nurses (DON) on 04/23/25 at 11:35 AM, the DON stated that there were allegations of abuse, facility reported incidents, or complaints regarding Resident #4. The DON stated that S/he would look in the administrative forms for a completed grievance form regarding Resident #4. Review of Resident #4's physical therapy progress notes on 04/25/25 revealed a physical therapy assistant (PTA#1) progress notes dated Monday, 10/21/24 at 3:53 PM that indicated Resident #4 was complaining of soreness in the right hip after an incident with Hoyer lift from Friday 10/18/24. A review of PTA#1's 10/23/24 progress note revealed that Resident #4 again complained of soreness in the right hip after being weighed on 10/22/24 while in bed. RTA#1 documented that Resident #4 complained of being hurt by the aides (geriatric nursing assistants) and not being able to get out of bed into a wheelchair. Resident #4 refused assistance by RTA#1 to help to get into the wheelchair and participate in group therapy. In an interview with PTA#1 on 04/25/24 at 12:24 PM, along with the Director of Therapy and the facility Director of Nurses, PTA#1 stated that Resident #4 complained of pain the first time PTA#1 seeing Resident #4 on 10/21/24. On 10/23/24, PTA#1 stated seeing Resident #4 for physical therapy. PTA#1 indicated that Resident #4 stated that S/he felt like the aides hurt him/her. RTA#1 stated that Resident #4 was not asked to elaborate how the staff hurt him. RTA#1 stated that S/he informed the Director of Therapy about Resident #4's allegation of being hurt be staff. RTA#1 stated that S/he did not notify any other facility administrative staff of Resident #4's allegation of being hurt by staff. In an interview with RN#5, a nursing unit manager, on 04/23/25 at 12:41 PM, RN#5 stated that S/he received a concern form from Resident #5 on 10/25/24. RN#5 stated that S/he addressed Resident #4's concerns on 10/26/24. RN#5 documented the following nursing actions that were implemented on , 10/26/24 regarding Resident #4: 1) Resident asked to a physician on 10/21/24. The nurse practitioner went in and saw Resident #4 and answered all questions, 2) Resident #4 complained of heartburn. The nurse practitioner ordered the medication, Tums, orally every 6 hours as needed, 3) Unit manager spoke with the staff and asked the staff to be more gentle/cautious with Resident #4's lower extremities, 4) Unit manager met with Resident #4 and asked him/her to use the call bell for assistance when transferring, to be patient if the aides/nurses are with other residents and it could take a few minutes before staff to come in and assist. Educated Resident #4 on waiting for assistance due to being assessed as a high fall risk. Resident #4 verbalized understanding. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN#5 was asked to provide the staff sign in sheets that demonstrated what nursing staff had received the education regarding Resident #4. RN#5 stated that there are no records of what education or the staff that received the education regarding Resident #4 from 10/26/24. Further review of Resident #4's closed medical record failed to reveal Resident #4 received a dose of Tums between 10/21/24 and 10/26/24. Further review of Resident #4 closed medical record revealed a 10/26/24, 10:48 AM nursing progress that indicated Resident #4 requested to go to the emergency room . The nurse contacted the on-call nurse practitioner and was given instructions that it was okay for Resident #4 to dial 911. A review of Resident #4's 10/26/24 hospital record revealed Resident #4 arrived at the emergency room at 12:55 PM by 911 ambulance with a chief complaint of heartburn and chest pain and requested not to be returned to the nursing facility. Resident #4 was admitted to the hospital with diagnoses that included: Atypical chest pain, ambulatory dysfunction, and neglect of an adult.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on complaint, reviews of all pertinent documentation and clinical records, and staff interview, it was determined that facility staff failed to implement parts of a comprehensive care plan for a resident. This was evident for 2 (Resident #6, #7) of 8 residents reviewed during a complaint survey. The findings include: A care plan is an outline of nursing care showing all the resident's needs and the ways of meeting the needs. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the individual's specific needs. It is a dynamic document initiated at admission and subject to continuous reassessment and change by the nursing staff caring for the resident. The care plan typically includes nursing and medical diagnoses, nursing interventions, and outcomes to ensure consistency of care. 1) Review of complaint MD00201378 on 04/28/25 revealed an allegation Resident #6 was not receiving care and services to heal a sacral wound. Review of Resident #6's clinical record on 04/28/25 revealed Resident #6 was admitted to the facility on [DATE] with diagnoses that include: quadriplegia, recent placement of a gastrostomy tube on 02/19/25, and contractures of the right and left ankles. On 04/04/25 the nursing staff obtained a wheelchair weight of 113.0 pounds. Review of Resident #6's care plans revealed a nursing care plan to address Resident #6's new feeding tube that was initiated on 02/23/25. Nursing interventions included: 1)Resident will be able to tolerate the tube feeding and water flushes. 2) Assist the resident with the tube feeding and water flushes. 3) Check the tube for placement and gastric content/residual volume per facility protocol and record. Hold resident's tube feeding if greater than 100 cc aspirate. 4) Provide local care to the G-tube site as ordered and monitor for signs and symptoms of infection. A review of Resident #6's medication and treatment administration records for February, March and April 2025, the nursing staff are not documenting the nursing intervention to check Resident #6's feeding tube for placement and gastric residuals and recording the results. 2) Review of complaint MD00201176 on 04/28/25 revealed an allegation Resident #7 did not receiving quality of care and had an unexpected death. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's clinical record on 04/28/25 revealed Resident #7 was admitted to the facility on [DATE] with diagnoses that included: dementia, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, and gate abnormality. Review of Resident #7's care plans revealed a nursing care plan to address Resident #7's being a nutritional risk related to variable meal intake, CHF, dementia, diabetes, and COPD. This nutritional risk care plan was initiated on 11/07/23. The goal of the care plan was for Resident #7 to avoid any significant weight changes. The 11/07/23 care plan nursing interventions included: 1) To consult the dietician as needed. 2) To serve the diet as ordered. Regular diet, Regular texture, thin liquid consistency. 2) If Resident #7 consumes less than 50% of a meal, notify the nurse. 3) To monitor Resident #7's weights, labs, and intake as available. 4) Notify Resident #7's physician and dietician if resident has any significant weight changes. Further review of Resident #7's meal intake records for November and December 2023 revealed the following meals that Resident #7 consumed less than 50%: Breakfast Lunch Dinner 11/08/23 1 - 26-50% 1 - 26-50% - 11/09/23 0 - 0-25% - - 11/11/23 No documentation No documentation No documentation 11/13/23 - 1 - 26-50% - 11/14/23 - 1 - 26-50% 1 - 26-50% 11/15/23 - - No documentation 11/19/23 1 - 26-50% 0 - 0-25% - 11/21/23 Refused Refused - 11/22/23 - 0 - 0-25% - 11/26/23 1 - 26-50% Refused No documentation 11/27/23 No documentation No documentation - 11/28/23 No documentation No documentation Refused (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/29/23 1 - 26-50% Refused 0 - 0-25% 11/30/23 0 - 0-25% Refused 1 - 26-50% 12/01/23 Refused 0 - 0-25% 0 - 0-25% 12/02/23 - 1 - 26-50% 0 - 0-25% The nursing staff failed to implement the nursing intervention to notify Resident #7's nurse for 34 meals when Resident #7 ate less than 50% of a meal between 11/07/23 through 12/02/23.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a complaint and a medical record, and interviews with facility staff, it was determined that the facility failed to maintain or improve a resident's nutritional status after having a feeding tube placed. This was evident for 1 (Resident #6) of 8 residents reviewed during a complaint survey. The findings include: Review of complaint MD00201378 on 04/28/25 revealed an allegation Resident #6 is not receiving care and services to heal a sacral wound. Review of Resident #6's clinical record on 04/28/25 revealed Resident #6 was admitted to the facility on [DATE] with diagnoses that include: quadriplegia, recent placement of a gastrostomy tube on 02/19/25, a sacral pressure ulcer, malnutrition, and contractures of the right and left ankles. On 02/20/25 the nursing staff obtained a readmission mechanical lift weight of 113.8 pounds for Resident #6. On 02/26/25 at 7:01 AM, the nursing staff obtained a mechanical lift weight of 119.4 pounds for Resident #6. Review of Resident #6's care plans revealed a nursing care plan to address Resident #6's being a nutritional risk, malnourished, having a history of weight loss, and having a sacral wound. This nutritional risk care plan was initiated on 02/21/25. The goal of the care plan was for Resident #6 to gain safely weight over the next quarter to a desired weight of 125 pounds with a daily meal intake of 75-100% of each meal. Nursing interventions included: 1) To administer the physician prescribed diet as ordered. 2) If Resident #6 consumes less than 50% of a meal, notify the nurse and provide a bolus delivery of tube feeding. 3) To monitor Resident #6's weights, labs, and intake 4) Notify Resident #6's physician and dietician if resident has any significant weight loss. 5) administer supplements as ordered. Further review of Resident #6's medical record revealed an attending physician assessment note, dated 03/04/25 in which Resident #6's physician noted the 02/26/25 documented weight of 119.4 pounds on Resident #6 and indicated: Patient (Resident #6) is now gaining weight. Further review of Resident #6's medical record revealed that on 03/11/25 at 10:40 PM, the facility director of nurses (DON) struck out Resident #6's, 02/26/25 weight of 119.4 pounds and indicated this was incorrect documentation. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility staff documented a weight of 119.4 pounds for Resident #6 on 02/26/25. The nursing staff obtained a weight of 112.8 pounds on 03/11/25. The weight difference between the 02/26/25 weight of 119.4 pounds and the 03/11/25 weight of 112.8 pounds is a weight loss of 6.6 pounds (5.5%). This significant weight loss occurred in a 3-week period for Resident #6 (02/19/25 through 03/11/25). In an interview with the facility DON on 05/01/25 at 11:50 AM, the facility DON stated that s/he struck out Resident #6's 02/26/25 weight of 119.4 pounds on 03/11/25 because the weight of 119.4 pounds was to be recorded in another resident's medical record. The DON stated that s/he did not notify Resident #6's physician at the time the weight of 119.4 pounds noted to be a mistaken entry on 03/11/25. After 02/26/25, the facility staff documented the following weights for Resident #6: 03/05/25 - 114.8 pounds by mechanical lift. 03/11/25 - 112.8 pounds by mechanical lift. 03/20/25 - 113.2 pounds by mechanical lift. 04/04/25 - 113.0 [pounds by wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215316	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Baltimore Washington	313 Hospital Drive Glen Burnie, MD 21061

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 18819 Based on reviews of closed and active medical records, reviews of all pertinent administrative records, and staff interviews, it was determined that the facility failed to have a system in place to ensure clinical records were complete and accurately documented. This was found to be evident for 2 (Residents #1, #4) of 8 residents reviewed during the complaint survey. The findings include: Documentation is an integral part of medication administration. Documentation communicates the timing, dosing, and effect of any medications received by a patient. In the setting of skilled nursing care, residents are often prescribed multiple medications for significant medical conditions. They are also often more vulnerable to medication errors and more prone to changes in condition that require review and adjustment of their medication regimen. Inaccurate medication documentation has the potential to place residents at significant risk of medication error, provide incomplete or inaccurate information for providers and care givers to evaluate, and represents a failure of basic medication administration principles. Late documentation is a form of inaccurate documentation and is worsened if the documentation does not document when medications were given. 'Late administration' is defined as giving medication greater than 1 hour after a medication is due. 'Late documentation' is defined as not documenting immediately after administration. A review of the facility Controlled Substance Administration and Accountability policy revealed a general protocol section, item f, that indicated: In all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the MAR, Controlled Drug Record, or other facility specified form and placed in the patient's medical record. 1) Review of Resident #1's closed medical record on 04/18/25 revealed a controlled medication utilization record that was issued by the facility pharmacy on 01/19/25 for the pain medication, Oxycodone, Immediate release, 5 milligrams, orally, as needed every four hours for pain. 27 doses were issued to the facility for Resident #1 on 01/19/25. Further review revealed that 2 doses had been signed out by a licensed nurse on the controlled medication utilization record 01/28/25 and 02/01/25. A review of Resident #1's January 2025 medication administration record (MAR) revealed that no doses of the Oxycodone were documented as being administered to Resident #1 in January 2025. A review of Resident #1's February 2025 medication administration record (MAR) revealed that one dose of the Oxycodone was administered to Resident #1 on 02/01/25 at 5 AM. 1 doses of Oxycodone signed out from the controlled medication utilization record by a licensed staff member could not be accounted for in Resident #1's clinical record. In an interview with the facility Director of Nurses (DON) on 04/21/25 at 12:55 PM, the DON confirmed that there is no nursing documentation to indicate Resident #1 received one dose of Oxycodone signed out by the licensed nursing staff on 01/28/25 at 11:30 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215316	A. Building B. Wing	05/02/2025

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Autumn Lake Healthcare at Baltimore Washington	313 Hospital Drive Glen Burnie, MD 21061

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of Resident #4's closed medical record on 04/24/25 revealed a controlled medication utilization record that was issued by the facility pharmacy on 10/18/24 for the pain medication, Oxycodone, Immediate release, 5 milligrams, orally, as needed every six hours for pain. 28 doses were issued to the facility for Resident #4 on 10/18/24. Further review revealed that 10 doses had been signed out by a licensed nurse. A review of Resident #4's October 2024 medication administration record (MAR) only revealed that 3 doses of the Oxycodone were administered to Resident #4 (10/18/24 at 11 PM, 10/20/24 at 10 PM, 10/24/24 at 8:48 AM). 7 doses of Oxycodone signed out from the controlled medication utilization record by a licensed staff member could not be accounted for in Resident #4 clinical record. In an interview with the facility Director of Nurses (DON) on 04/30/25 at 1:25 PM, the DON confirmed that there is no nursing documentation to indicate Resident #4 received the 7 doses of Oxycodone signed out by the licensed nursing staff between 10/18/24 and 10/26/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on complaint, observation, reviews of all pertinent documents and clinical records, and resident interview, it was determined that the facility staff failed to ensure that a resident's bed could adequately meet the resident's needs. This was evident for 1 (Resident #6) of 8 residents reviewed during a complaint survey. The findings include: Review of complaint MD00201378 on 04/28/25 revealed an allegation Resident #6 was not being groomed, bathed, or shaved. Resident #6 also had a bed sore. Review of Resident #6's clinical record on 04/28/25 revealed Resident #6 was admitted to the facility on [DATE] with diagnoses that include: quadriplegia, gastrostomy tube, and contractures of the right and left ankles. On 01/11/25 the staff obtained a height of 73 inches. On 04/04/25 the nursing staff obtained a wheelchair weight of 113.0 pounds. During an observation of Resident #6 on 05/02/25 at 10:45 AM with the facility director of nurses (DON), the surveyor observed Resident #6's right and left feet hanging over the bottom of the bed over the foot board. Resident #6 suffers from right and left ankle foot drop. The nursing staff apply bilateral foot drop prevention boots onto Resident #6's feet/ankles daily. The foot drop boots further extend the length of Resident #6's legs. Resident #6 was able to state to the DON that the length of the bed was to small.