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	02/13/2026

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 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 observation, interviews, and surveyor record reviews it was determined that the facility failed to complete assessments accurately for residents. This was found to be evident in 5 (Resident #2, #7, #10, #31 and #126) out of 44 residents reviewed for Minimum Data Set (MDS) assessments. The findings include:Minimum Data Set (MDS) assessment is a federally mandated, standardized, comprehensive clinical assessment tool used in Medicare and Medicaid certified nursing homes. The MDS evaluates Residents' functional, cognitive, and physical health, guiding care plans to meet individual needs. Completed upon admission, quarterly, annually and whenever a significant change in condition occurs by trained clinicians. Care Plan is a tailored document summarizing a person's health conditions, care needs, medications, and goals and interventions designed to ensure consistent, proactive care. The care plan acts as a roadmap improving communication between providers, fostering patient independence, and enhancing safety. The care plan is evaluated on a regular basis to assess effectiveness and update as needed. 1.On 2/8/2026 at 11:08 AM the surveyor observed Resident #2 in bed, in no distress. The surveyor conducted an interview with Resident #2 who was alert and oriented x3 to person, place and time. Resident #2 stated that during a transfer he/she was lowered to the floor by 2 staff members because he/she was unable to bear weight. The surveyor conducted a record review of Resident #2's medical record at 9:30 AM on 2/12/2026. The record review revealed that Resident #2 had a change in condition evaluation on 11/10/2024 for a witnessed fall – 2 GNAs (Geriatric Nursing Assistant) transferring Resident from bed to wheelchair, Resident's knees buckled and Resident was lowered to the floor. Further review of the medical record for Resident #2 revealed that the Discharge – Return Anticipated MDS assessment dated [DATE] Section J was not coded for Resident having had any falls. At 8:50 AM on 2/13/2026 in an interview with the RN MDS Coordinator the surveyor conveyed that Resident #2 had a fall (lowered to the floor) on 11/10/2024, but the Discharge MDS dated [DATE] was not coded that Resident had any falls. MDS Coordinator reviewed the change in condition evaluation and the Discharge MDS and stated that the 11/30/2024 Discharge MDS should have been coded that Resident had a fall due to Resident being lowered to the floor on 11/10/2024. The MDS Coordinator stated that she would make the correction to the 11/30/2024 Discharge MDS to reflect that Resident #2 had a fall. On 2/13/2026 at 12:36 PM the surveyor conveyed to the Director of Nursing (DON) that the fall for Resident #2 was not coded on the Discharge MDS assessment dated [DATE] and that the MDS Coordinator was making a modification to the MDS to code the fall. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/10/2026 at 3:15 PM the surveyor conducted a record review of Resident #126's medical record. Review of the medical record revealed that there was a physician order on 10/15/2024, Admit to Hospice for Resident #126. Further review of the medical record revealed that there was a care plan for Hospice care. Review of Resident #126's MDS Quarterly assessment dated [DATE] Section O was not coded for Hospice care. In an interview with the RN MDS Coordinator at 7:20 AM on 2/11/2026 the surveyor reviewed the MDS assessments for Resident #126. The MDS Coordinator confirmed that Resident #126 was admitted to Hospice services on 10/15/2024 and that the Quarterly MDS assessment dated [DATE] was not coded for Hospice care. The MDS Coordinator stated that she would make the correction to the 1/23/2025 Quarterly MDS to reflect Hospice care for Resident #126. At 7:35 AM on 2/11/2026 the Director of Nursing (DON) was notified of the inaccurate MDS assessment dated [DATE] for Resident #126 regarding Hospice care. 2. On 2/9/26 at 9:52 AM, the surveyor reviewed Resident #7's medical record. The review revealed that Resident #7 had received the influenza vaccine on 9/22/25. Next the surveyor reviewed the Minimum Data Set (MDS) assessment dated [DATE] for Resident #7. In section O the question is asked, did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? Resident #7's assessment documented no. A follow up question was, if influenza vaccine not received, state reason. The response to this question was, Not offered. On 2/9/26 at 1:50 PM, the surveyor conducted an interview with the MDS coordinator Staff #2. During the interview the MDS coordinator reviewed the assessment dated [DATE] and confirmed that Resident # 7 received the vaccination and the MDS assessment was inaccurate. She further stated she would correct the error. On 2/9/26 at 9:52 AM, the surveyor reviewed Resident #10's medical record. The review revealed that in Resident #10's immunization record it was recorded that Resident #10 had refused the influenza vaccine on 12/10/25. It was also documented he/she was educated on the risks and benefits of the vaccination. An additional drop down area in immunizations also documented the Resident #10 received the influenza vaccination during the current influenza season in historical data. Next the surveyor reviewed the Minimum Data Set (MDS) assessment dated [DATE] for Resident #10. In section O the question is asked, did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? Resident #10's assessment documented no. A follow up question was, if influenza vaccine not received, state reason. The response to this question was, Offered and declined. On 2/9/26 at 1:33 PM, the surveyor conducted an interview with Assistant Director of Nursing (ADON) #3. During the interview ADON #3 stated that the nurse offered the vaccine on admission to the Resident and it was documented as refused that day, however after checking the historical data the vaccine was already administered for the 2025-2026 flu season. On 2/9/26 at 1:50 PM, the surveyor conducted an interview with the MDS coordinator Staff #2. During the interview the MDS coordinator reviewed the assessment dated [DATE] and confirmed that Resident # 10 received the vaccination and the MDS assessment was inaccurate. Staff #2 stated that she was (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unaware of the drop down box when review of historical data captured vaccination status. She further stated she would correct the error. 3. On 2/8/2026 at 9:09 AM, the surveyor interviewed Resident #31 and during that interview the resident stated that they had been diagnosed with Rheumatoid Arthritis approximately 20 years ago and had been in constant pain since. They reported that they had reported their pain and the intensity to the staff and had not received any medication for relief most of the time. On 2/9/2026 at 10:45 AM , the surveyor reviewed Resident #31 's medical records. The review revealed that Resident #31 had a standing order for Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg to be given every 8 hours with the resident's pain level, on a 0 (no pain) to 9 (extreme pain), to be recorded on the Medication Administration Record (MAR). The pain level was inconsistently entered with a large number of 0 even though the resident stated that she is never without pain and that not all nurses that brought medication asked about how bad the pain was. There were also X's were the pain level was not recorded. The surveyor spoke with Employee #24 who stated that the nursing staff had been instructed to ask the resident about their pain and to record the level on the MAR. The employee stated they could not explain the inconsistency. The surveyor also noted that during the medical record review, the Skilled Nursing Charting PDPM also indicated that resident had stated they had no pain. Again the resident denied ever being without pain. Further review of Resident #31 's medical record revealed an as needed (PRN) order for Extra Strength Tylenol 500 mg, as needed for chronic pain. This medication was only given once during the first two weeks of February, 2026, though the resident reported having asked for pain medication almost daily.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, it was determined that the facility failed to develop and implement comprehensive care plans for residents. This finding was found to be evident in 4 (Resident # 2, #19, #31 and #136) out of 44 residents reviewed for comprehensive care plans. The findings include: Care Plan is a tailored document summarizing a person's health conditions, care needs, medications, and goals with interventions to ensure consistent care and improve quality of life. It acts as a roadmap for caregivers and providers to organize, prioritize, and manage daily care. 1) During an interview at 9:14 AM on 2/8/2026 with Resident #136 the surveyor observed that Resident had an intravenous (IV) antibiotic mini bag on the IV stand in the Resident Room. On 2/10/2026 at 11:10 AM the surveyor conducted a record review of Resident #136's medical record. Review of the medical record revealed that Resident #136 did not have a comprehensive care plan for the intravenous antibiotic and care of the intravenous access site. Additionally, Resident #136 had an incomplete care plan that addressed a mid-back surgical site and dermatitis (inflammation of the skin) but did not have goals and interventions included in that care plan. In an interview with the Director of Nursing (DON) on 2/10/2026 at 12:58 PM the surveyor reviewed with the DON that there was not a care plan for the IV antibiotic medication and care of the intravenous access site, and the care plan for the surgical site and the dermatitis was incomplete without goals and interventions. The DON acknowledged the surveyor and stated that the care plan was not reactivated when Resident #136 returned from hospital on 1/24/2026. Anticoagulant medication, or blood thinners prevent dangerous blood clots in veins, arteries, and the heart, reducing stroke and heart attack risk. These medications work by inhibiting specific clotting factors in the blood, with major side effects including increased bleeding. Deep Vein Thrombosis is a serious condition where a blood clot forms in a deep vein, usually in the legs or pelvis, causing swelling, pain, warmth, and redness. Caused by reduced blood flow or vein injury, it can lead to fatal pulmonary embolism. Treatment includes blood-thinning medications. The surveyor conducted a record review of Resident #19's medical record on 2/10/2026 at 12:30 PM. Record review revealed that Resident #19 had a care plan with interventions for monitoring signs and symptoms abnormal bleeding and bruising related to anticoagulant use. Review of the active physician orders revealed that Resident #19 did not have an order for anticoagulant medication, and further review of the discontinued physician orders did not reveal that Resident ever received an anticoagulant medication while at the facility. Resident was admitted on [DATE]. Additionally, review of the discharge summary from the hospital in November 2025 indicated that Resident #19 had a history of a deep vein thrombosis (DVT) and was not anticoagulated. In an interview with the Director of Nursing (DON) at 2:20 PM on 2/10/2026 the surveyor conveyed to DON that Resident #19 did not have an order for anticoagulant medication but had a care plan for DVT with an intervention for monitoring abnormal bleeding and bruising related to anticoagulant use. DON stated that it was the responsibility of the clinical team to implement and update the care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An RN MDS Coordinator is a specialized Registered Nurse in skilled nursing facilities who manages the Minimum Data Set (MDS) assessment. The RN MDS Coordinator assesses, documents, and codes a patient's functional, medical, and psychosocial status for federal/state compliance, care planning, and reimbursement. Minimum Data Set (MDS) assessment is a federally mandated, standardized, comprehensive clinical assessment tool used in Medicare and Medicaid certified nursing homes. The MDS evaluates Residents' functional, cognitive, and physical health, guiding care plans to meet individual needs. Completed upon admission, quarterly, annually and whenever a significant change in condition occurs by trained clinicians. On 2/12/2026 at 9:30 AM the surveyor conducted a record review of Resident #2's medical record. Review of the medical record revealed that Resident #2 had a fall on 11/10/2024 and had a medical diagnosis of history of falling. Further review of the medical record revealed that Resident #2's comprehensive care plan did not have a problem, goal or interventions for at risk for falls or an actual fall. Additionally, Resident #2 had a physician order for Eliquis 5 mg 2 times daily for atrial fibrillation (cardiac arrhythmia) but Resident did not have a comprehensive care plan for the Eliquis (anticoagulant medication) or the atrial fibrillation. In an interview with the Director of Nursing (DON) at 7:00 AM on 2/13/2026 the surveyor conveyed to the DON that there was not a care plan for the cardiac condition or the anticoagulant medication. DON acknowledged the surveyor. In an interview with the RN MDS Coordinator at 8:50 AM on 2/13/2026 the surveyor conveyed that Resident #2 had a fall on 11/10/2024 in the facility and had a diagnosis of history of falling but did not have a care plan for falls or at risk for falls. RN MDS Coordinator acknowledged the surveyor. No additional information was provided by the facility at the time of survey exit. 2) On 2/8/2026 at 9:09 AM, the surveyor interviewed Resident #31 and during that interview the resident stated that they had been diagnosed with Rheumatoid Arthritis approximately 20 years ago and had been in constant pain since. They reported that they had reported their pain and the intensity to the staff and had not received any medication for relief most of the time. On 02/12/2026 9:12 AM During the medical record review, it was discovered that there was no care plan for pain management even though Rheumatoid Arthritis is the primary medical diagnosis and the resident is prescribed both standing order medication and as needed medication (PRN) for pain. The resident is prescribed Hydrocodone-Acetaminophen 7.5-325mg every 8 hours; Lyrica 100mg twice daily; and a Lidocaine External Patch applied once daily; and Capsaicin 0.075% every 6 hours. In addition to the standing orders the resident is also prescribed Extra Strength Tylenol 500mg every 8 hours as needed. There was no mention of the resident's pain or the measures the facility were taking to relieve there pain in the initial care plan update on 1/30/2026, 72 hours after the resident's admission. According to the progress note on 1/30/2026, there were no medical or nursing staff in attendance at the care plan meeting. On 02/12/2026 at 11:50 AM, Employee #18 was asked about why pain management wasn't included in the care plan and they said they didn't know.