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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations and interviews it was determined that the facility failed to maintain a safe, clean, comfortable, homelike environment for residents. This finding was found to be evident in 13 (#4, #7, #9, #10, #20, #21, #23, #25, #26, #27, #36, #37 and #107) out of 25 resident rooms and other facility common areas reviewed for physical environment during the recertification survey. The findings include:1.On 02/08/26 at 9:50 AM, the surveyors observed room [ROOM NUMBER]'s trash can overflowing with trash on the floor surrounding it, accumulated dust in the window and blinds, deeply scuffed areas in the floor and a partially detached door panel that was hanging loose. On 02/08/26 at 9:57 AM, the surveyors discovered a commode seat that was stained with a brown substance, a missing toilet rod and wrapped toilet paper that was not within reach in room [ROOM NUMBER]'s bathroom. On 02/08/26 at 11:06 AM, the surveyors observed that room [ROOM NUMBER] had a dead spider, cobwebs, and dust on and around the window. On 02/13/26 at 11:40 AM, the Administrator acknowledged the environmental concerns found in the facility. 2.On tour of Resident rooms on nursing units 1 and 2 of the facility on 2/8/2026 at 8:15 am the surveyor observed several Resident rooms that were not in good repair and not clean. room [ROOM NUMBER] – cracked faucet and no rod for the toilet paper in the dispenser in shared bathroom, no trash bag in trashcan; room [ROOM NUMBER] and 27 – marred bathroom doors; room [ROOM NUMBER], 26 and 36 – marred walls; room [ROOM NUMBER] – trash can with crack and no trash bag in the trash can; room [ROOM NUMBER] – trash can overflow with trash on the floor and marred room door. During an interview with Resident #128 in room [ROOM NUMBER] on 2/8/2026, he/she stated that the toilet paper was placed on the grab bar in the bathroom because there was no rod for the toilet paper. On 2/13/2026 at 6:56 AM the Licensed Nursing Home Administrator (LNHA) was notified of the concerns with the facility regarding the physical environment. At the exit conference on 2/13/2026 the administrative staff was notified of the concerns with the facility regarding a safe, clean, comfortable, homelike environment. 3.On 2/10/2026 at 10 AM, a tour of the facility with the Maintenance Director revealed: (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The shower room on Station 3 had One non-working ceiling light in one of the shower stalls, one over-bed table, one shower chair with a brown stain on the seat, The shower lever in that stall was also missing. On 2/20/2026 at 10:18 AM further tour of the facility with the Maintenance Director revealed: A cracked window covered in dark gray tape in room [ROOM NUMBER], A white blanket on the window sill in room [ROOM NUMBER], the resident and their roommate stated that on cold days, there is a draft felt from that part of the window, room [ROOM NUMBER]-A the metal heated baseboard severely damaged and pulled away from the wall. A tour was conducted with the Director of Housekeeping on 2/10/2026 at 10:46 AM which revealed: The Larger shower room on Station 3 had a bag of resident gowns in a plastic bag on the shower floor of the first shower stall; the second shower stall contained a large white trash can, a visibly soiled dark blue chair cushion; and the third shower stall contained a linen cart for soiled linens. A room at the back end of the shower room that had 3 floating shelves stacked with folded gowns, blankets, sheets, and reusable bed pads-- all of which were uncovered; a black manual wheelchair with folded lines stacked on the seat. Station 1 shower room, with a brown stain on the shower curtain Rooms on Station 2 and on Station 1 were toured and the surveyor conveyed the the concern that the windows in several of the resident rooms that were observed had dirt/debris and cobwebs. At 11 AM on 2/10/2026 the Director of Housekeeping confirmed that all the concerns identified during the tour were addressed immediately. 4.On 2/8/26 at 7:07 AM, upon initial entrance into the facility, the surveyor walked down and observed the dining room. The surveyor noted napkins and wrappers around the garbage can located by the dining hall entrance doors. On further review, the surveyor observed items left on a table that appeared to have been left from a mealtime. They consisted of a butter knife, spoon, plastic top to a small container, a crumpled-up napkin and an empty cup on its side. Several other tables had napkins crumpled-up and under the tables. One tabletop had what appeared to be paint splattered on top. The surveyor was able to wipe some of the paint residue off. On 2/8/26 the surveyor walked down the hallway and noticed garbage cans next to the resident's beds that were filled to the top. This was observed as follows: 8:39 AM room [ROOM NUMBER] bed A- garbage full 9:04 AM room [ROOM NUMBER] bed A- garbage full 9:21 AM room [ROOM NUMBER] bed A -garbage full (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/8/26 at 1:49 PM, the surveyor reviewed the observations with the Nursing Home Administrator (NHA). He stated that housekeeping services were on site the day before and he would have expected the trash on the floor and garbage addressed.

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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 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on facility staff and Resident interviews and surveyor record review, it was determined that the facility failed to update and revise Resident care plans and failed to conduct Resident care plan meetings for 4 (Resident #2, 5, 75, and 126) out of 7 Residents reviewed for care plan timing and revision.The findings include: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.On 2/8/2026 at 8:41 AM in an interview with Resident #5, Resident stated that he/she was not aware of a care plan meeting.The surveyor conducted a record review on 2/10/2026 at 9:30 AM of Resident #5's medical record and review of the medical record revealed care plan meeting attendance reports for 10/10/2024, 1/17/2025 and 9/18/2025 that were in the misc. tab of the electronic medical record.In an interview with the Director of Nursing (DON) at 11:30 AM on 2/10/2026 regarding the care plan meetings for the past year, she stated that she would follow up and check Resident #5's chart.In a follow up interview with the DON on 2/10/2026 at 1:00 PM she provided the surveyor with copies of the care plan attendance reports for 10/10/2024, 1/17/2025 and 9/18/2025, and stated that these were the only care plan meeting attendance reports that were in Resident #5's chart. The DON confirmed that there were no care plan meeting attendance sheets for April 2025 and July 2025.On 2/8/2026 at 11:17 AM in an interview with Resident #2 at 11:17 AM Resident stated that he/she was not aware of care plan meeting.The surveyor conducted a record review on 2/10/2026 at 10:00 AM of Resident #2's medical record and review of the medical record revealed care plan meeting attendance reports for 12/19/2024, 6/12/2025, 9/11/2025, 11/4/2025, 11/14/2025 and 12/5/2025 that were in the misc. tab of the electronic medical record.In an interview with the Director of Nursing (DON) at 11:30 AM on 2/10/2026 regarding the care plan meetings for the past year, she stated that she would follow up and check Resident #2's chart.In a follow up interview with the DON on 2/10/2026 at 1:00 PM she provided the surveyor with copies of the care plan attendance reports for 6/12/2025,11/4/2025,11/14/2025 and 12/5/2025 and stated that these were the only care plan meeting attendance reports that were in Resident #2's chart. The DON confirmed that there was no care plan meeting attendance sheet for March 2025.The surveyor conducted a record review of Resident #126's medical record on 2/11/2026 at 8:37 AM. Record review revealed that Resident #126 had a care plan for antibiotic therapy (Cipro) for infection of the back. Review of the current active physician orders did not reveal that Resident #126 had an active antibiotic order for Cipro. Further review of the care plan indicated that the antibiotic therapy care plan for Cipro was initiated on 11/3/2025. Review of the discontinued/completed physician orders revealed that Resident #126 received the antibiotic - Nitrofurantoin) in November 2025 for 7 days but did not have an order for Cipro.In an interview with the Director of Nursing (DON) on 2/11/2026 at 9:45 AM the surveyor conveyed that Resident #126 had a care plan for antibiotic therapy (Cipro) that was initiated on 11/3/2025 and that the Resident does not have a current physician order for antibiotic therapy, Cipro. DON acknowledged the surveyor and stated that it was the clinical team's responsibility to update the care plans.On 2/12/2026 at 7:45 AM the surveyor conducted a record review of Resident #75's medical record. Review of the medical record revealed that Resident #75 had a care plan for antibiotic therapy related to infection/pneumonia. Review of the active/current physician orders did not reveal that Resident #75 was receiving an antibiotic for pneumonia. Further review of the care plan revealed that the care plan for antibiotic therapy was initiated on 8/6/2025. Review of the discontinued/completed physician orders for Resident #75 revealed that Resident received antibiotic therapy (Zithromax Z-pak - Azithromycin) in August of 2025 for 5 days for pneumonia.In an interview with the Director of Nursing (DON) on 2/12/2026 at 8:15 AM the surveyor (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conveyed that Resident #75 had a care plan for antibiotic therapy that was initiated on 8/6/2025 and that the Resident does not have a current physician order for an antibiotic. DON acknowledged the surveyor.No additional information was provided by the facility at the time of survey exit.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record reviews, and interviews it was determined that the facility failed to utilize professional standards during, 1) tube feeding administration, 2) pressure ulcers and 3) unnecessary medications. This was found to be evident in 4 (#1, #2, #5, and #75) out of 9 residents reviewed during the recertification survey. The findings include: Enteral nutrition, also known as tube feeding, is a way to deliver dietary needs directly to the stomach or small intestine. A gastrostomy tube or (g-tube) is used when nutrition is delivered to your stomach. A common g-tube placed is called a percutaneous endoscopic gastrostomy (PEG) tube. This is done by a surgical procedure. 1) On 2/8/26 at 8:25 AM, the surveyor observed Resident #1 had a container of tube feed on his/her table labeled and dated. No tubing was noted, however there was a syringe on the table. On 2/10/26 at 9:48 AM, the surveyor reviewed Resident #1's orders. The review revealed an order placed on 9/24/25 that stated, every night shift the enteral feeding tubing to be changed along with the syringe. An additional order stated, Resident #1 to receive tube feeding (Jevity 1.5) bolus (300ml) via gravity 4 times per day at midnight, 6am, noon, and 6pm. On 2/12/26 at 6:22 AM, the surveyor observed no tube feeding was infusing for Resident #1. A tube feeding container was again noted on the bedside with a syringe. The bottle was sealed closed and no tubbing was noted. On 2/12/26 at 6:57 AM, the surveyor interviewed Resident #1's nurse Licensed Practical Nurse (LPN) #25. During the interview the surveyor asked when Resident # 1's was scheduled for tube feeding administration during his shift. LPN #25 stated he administered Resident #1 his/her feeding at 4 or 5 AM. The surveyor asked how the tube feeding was administered. LPN #25 stated that he used a syringe. He further stated that he poured the correct volume from the bottle into a cup and then poured the tube feeding into the syringe and fed via gravity. The surveyor confirmed that no tubing was utilized for the gravity tube feeding. On 2/12/26 at 8:33 AM, the surveyor reviewed Resident #1's February Medication Administration Record (MAR) with the Director of Nursing (DON). The review revealed that both the midnight and 6am administration of tube feeding were not marked as administered even though LPN #25 stated that he administered the tube feeding to Resident #1 at either 4 or 5 am. The DON stated that if the tube feeding was given the MAR should record the administration. She stated that she would reach out to the nurse and find out why the administration was not documented. On 2/12/26 at 10:37 AM, the surveyor conducted a follow up interview with DON. During the interview the surveyor asked how tube feeding should be administered with the use of multidose containers. The DON stated per manufacture guidelines and resident orders. The surveyor reviewed the concern that staff were using multidose containers of tube feeding formula and administer the tube feeding via syringe (not the attend way of administration). The surveyor asked for the manufacturer's guidelines for Jevity 1.5 Cal multidose container, the formula that Resident #1 received. On 2/12/26 at 11:25 AM, the surveyor reviewed the guidelines for Jevity 1.5 Cal. The product description stated the formula could come in two forms, a 235 milliliter can or 1.5 liter ready-to-hang and container. The can instructions stated that once opened, the can should be covered, refrigerated and used within 48 hours. The ready-to-hang container, the one that was in Resident #1's room, noted (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failure to follow the instructions for use increase the potential for microbial contamination and may reduce hand times. The instructions stated for gravity feeding, to use a 12 French (a commonly used, moderate-sized medical catheter with an outer diameter of 4.0 mm) or larger tube. The precautions stated to follow directions for the use provided by the manufacture of feeding sets. (tubing) Following the review of the manufacturer's guidelines the surveyor reviewed the concerns with the Director of Nursing (DON) that the facility was not following the manufacturers guidelines and as the instructions stated, there was an increase risk of microbial growth and contamination. The surveyor also reviewed the concern that tube feeding administration was not benign documented after the tube feeding was administered. Cross reference F693 Medication and Treatment Administration Record (MAR/TAR) is a legal, essential document in healthcare used to track, schedule, and document the administration of medications and treatments to Resident. It ensures safety, accuracy and real time documentation that prevents errors, provides a clear, unbroken record of care, and supports medication monitoring. Stage 2 Pressure Ulcer is a partial-thickness skin loss involving damage to the epidermis and part of the dermis, appearing as a shallow, open, pink/red wound or an intact/ruptured serum-filled blister. These wounds are painful, involve no fat or deeper tissue exposure, and often occur over bony prominences. 2) The surveyor conducted a record review of Resident #5's medical record on 2/11/2026 at 3:15 PM. Record review revealed that Resident #5 had a Wound Assessment Report dated 12/24/2025 that the stage 2 pressure ulcer/injury was resolved to the left buttock and there was no treatment indicated. Review of the physician orders indicated that Resident #5 had an active order for treatment for the left buttock stage 2 pressure ulcer for the month of January and February 2026. Review of the medication/treatment administration records for January and February 2026 revealed that the nursing staff was signing that the treatment was being performed daily. The surveyor conveyed to the Director of Nursing (DON) at 7:10 AM on 2/12/2026 that Resident #5 had a resolved pressure ulcer on 12/24/2025 but there was an active physician order for treatment to the healed pressure ulcer, and the nursing staff was documenting on the medication/treatment administration record that the treatment was being performed daily for January and February 2026. The DON stated that she would review this. Antipsychotic medication is a psychoactive drug used to manage psychosis symptoms like hallucinations and delusions by altering brain neurotransmitter activity. They function by reducing dopamine levels in the brain. Hypnotic medication (sedative) is a central nervous system depressant designed to induce sleep, commonly used for treatment of insomnia. They function by initiating and maintaining sleep. 3) On 2/12/2026 at 7:45 AM the surveyor conducted a record review of Resident #75's medical record. Review of the medical record revealed that Resident #75 had an active physician order for monitor for behaviors, Resident is on an antipsychotic medication, Zolpidem. Further review of the medical record revealed that Resident #75 was not prescribed an antipsychotic medication. Resident #75 had a physician order for Zolpidem 5 mg at bedtime for insomnia. Zolpidem was a hypnotic medication, not (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an antipsychotic medication. The surveyor conveyed to the Director of Nursing (ADON) at 8:15 AM on 2/12/2026 that Resident had a physician order for Zolpidem for insomnia, and had a physician order to monitor for behaviors, Resident is on antipsychotic medication, Zolpidem, but Resident did not have a physician order for antipsychotic medication. The DON acknowledged the surveyor. The surveyor conducted a record review of the medical record for Resident #2 at 9:15 AM on 2/13/2026. Review of the medical record revealed that Resident #2 received Insulin for Diabetes Mellitus. Resident #2 had physician orders for insulin to be given before meals and at bedtime based on the results of the Resident's blood sugar levels. Further review of the medical record revealed that there was no physician order for how much insulin to administer when the blood sugar was above the level of 400 for Resident #2. At 1:15 PM on 2/13/2026 in an interview with the Director of Nursing (DON) the surveyor reviewed the physician order for insulin for Resident #2. The surveyor conveyed that there was no physician order to administer insulin for a blood sugar result above 400. The DON stated that there should be a physician order to address the high blood sugar result above 400 for Resident #2. No additional information was provided by the facility at the time of survey exit.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, and interviews with facility staff, it was determined that the facility failed to provide an environment that promotes resident respect and dignity. This finding was evident in 1 of 44 residents (Resident #81) selected for this survey. The findings include: On 2/08/2026 at 8:45 AM surveyor observation of Resident #81 revealed a Foley catheter drainage bag (a Foley catheter is flexible tube which passes through the urethra and into the bladder to drain urine) hanging from the right side of the bed with no dignity bag (a bag which covers the Foley catheter's urine collection bag from plain sight) present. On 2/09/2026 at 9:30 AM, surveyor brought the Unit Manager into the room and asked her to identify the condition of the catheter collection bag. The Unit Manager acknowledged that there was no dignity bag over the collection bag. On 2/09/2026 at 1PM a tour of Resident #81's room with LPN #7 revealed that there was no privacy cover on Resident #81's Foley catheter drainage bag. LPN #7 confirmed that he/she or another nurse will retrieve and place a privacy cover on the drainage bag immediately.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on record review and interviews, it was determined that facility staff failed to get consent from a Resident's Responsible Party (RP) or representative related to vaccinations. This finding was evident for 2 (Resident #3 & 10) of 5 residents reviewed for vaccinations during the survey. The findings include: 1) On 2/9/26 at 9:52 AM, the surveyor reviewed Resident #3's medical record. The review revealed that Resident #3 had refused the influenza vaccine on 9/16/25 and was educated on the risks and benefits of the vaccination. This was noted in the immunization record. Next the surveyor reviewed a progress note written by Registered Nurse (RN) #3 dated 9/16/25 that stated, Resident #3 (self- RP) has declined the seasonal flu vaccination. On further review of the record the surveyor noted that Resident #3 had two certifications that stated Resident #3 lacked adequate decision making capacity both dated 3/25/25. Resident #3's family member was named active Power of Attorney (POA) for health care. 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 she offered the vaccination to Resident #3 and knew the resident had a history of refusing. The surveyor relayed the concern that the consent was not obtained from Resident #3's established RP. 2) On 2/9/26 at 9:52 AM, the surveyor reviewed Resident #10's medical record. The review revealed that Resident #10 had refused the influenza vaccine on 12/10/25 and was educated on the risks and benefits of the vaccination. This was noted in the immunization record. On further review, hospital discharge records documented that Resident #10 was discharged to the facility after a recent fall. The hospital records stated that Resident #10's aide had stated that Resident #10 was having difficulty walking prior to the fall. It also noted that Resident #10 had a past medical history that included but not limited to, autism spectrum, mental retardation and hearing loss. The hospital records included a contact person for Resident #10. 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. The surveyor relayed the concern that Resident #10 had an RP established and that the Resident was asked to consent and not the RP.

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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 observation and interview it was determined that the facility failed to maintain privacy for a Resident during meal delivery on the nursing units. This finding was found to be evident for 1 (Resident #75) out of 7 Residents reviewed for privacy.The findings include:At 8:52 AM on 2/8/2026 the surveyor observed employee #22 entering Resident #75's room without knocking on the door prior to entry. Employee #22 was delivering meal trays to Residents on the nursing unit.In an interview with Resident #75 on 2/8/2026, he/she stated that the staff does not always knock on the door when entering the room and that he/she and his/her roommate prefers the door open.On 2/13/2026 at 2:30 PM during survey exit the administrative team was notified of the concern with Resident privacy.

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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 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. 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 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined that the facility failed to ensure that residents had only one Maryland Order for Life-Sustaining Treatment (MOLST) form in their paper medical record. This was evident for 1 (Residents #1) of all residents present in the sample. The findings include: The Maryland Orders for Life-Sustaining Treatment (MOLST) form is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. It was designed to ensure that healthcare providers throughout Maryland have a uniform system of communicating a resident's end-of-life wishes in the event of cardiac or respiratory arrest. Cardiopulmonary Resuscitation (CPR) is the act of attempting to revive someone if their heart or breathing have stopped. On [DATE] at 8:19 AM, the surveyor reviewed Resident #1's paper medical record. The review revealed a MOLST dated [DATE] that indicated Resident #1 wanted CPR based on instructions in the patient's advanced directives. On [DATE] at 1:15 PM, the surveyor requested a copy of Resident #1's advanced directives and MOLST. On [DATE] at 1:45 AM, the surveyor reviewed the MOLST the Director of Nursing (DON) provided. The MOLST was dated [DATE] and indicated that Resident #1's surrogate decision maker elected to not have CPR performed in the case of cardiac arrest. The declination was Do Not Intubate (DNI). (This still allows limited ventilatory support by CPPAP or BIPAP). Along with MOLST the DON provided the surrogate decision making documentation as well as certifications by two provided indicating that Resident #1 was incapable of making medical decisions. All of these documents were dated April of 2024. Next the surveyor conducted an interview with the DON. During the interview the surveyor asked where the MOLST dated [DATE] came from. The DON stated she had found it in Resident's #1 paper medical record. The surveyor asked about the MOLST that was dated [DATE] seen earlier that day. The DON stated she would look and follow-up on the February 2025 MOLST. On [DATE] at 8:22 AM, the surveyor conducted a follow-up interview with the DON. During the interview the DON stated that both MOLSTs were located in Resident #1' medical record. The DON stated only one active MOLST should have been in the chart. She further stated that if there are two MOLST in the chart with contraindicating orders the staff reviews the date on the MOLST and would utilize the most recent date. The DON stated she removed the older MOST dating [DATE].

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews, record reviews, it was determined that the facility, staff failed to 1) ensure that the tube feeding container was labeled and 2) the facility failed to administer enteral tube feeding per manufacture's instructions. This was evident for 2 (#1 and #120) residents reviewed for tube feeding during the recertification survey. The findings include: Enteral nutrition, also known as tube feeding, is a way to deliver dietary needs directly to the stomach or small intestine. A gastrostomy tube or (g-tube) is used when nutrition is delivered to your stomach. A common g-tube placed is called a percutaneous endoscopic gastrostomy (PEG) tube. This is done by a surgical procedure. 1) On 2/8/26 at 8:25 AM, the surveyor observed Resident #1 had a tube feeding container on his/her table labeled and dated. No tubing was noted, however there was a syringe on the table. On 2/10/26 at 9:48 AM, the surveyor reviewed Resident #1's orders. The review revealed an order placed on 9/24/25 that stated, every night shift the enteral feeding tubing to be changed along with the syringe. An additional order was for Resident #1 to receive tube feeding (Jevity 1.5) bolus (300ml) via gravity 4 times per day at midnight, 6am, noon, and 6pm. On 2/12/26 at 6:22 AM, the surveyor observed no tube feeding was infusing for Resident #1. A tube feeding container was again noted on the bedside with a syringe. The bottle was sealed closed and no tubing was noted. On 2/12/26 at 6:57 AM, the surveyor interviewed Resident #1's nurse Licensed Practical Nurse (LPN) #25. During the interview the surveyor asked when Resident # 1's was scheduled for tube feeding administration during his shift. LPN #25 stated he administered Resident #1 his/her feeding at 4 or 5 AM. The surveyor asked how the tube feeding was administered. LPN #25 stated that he used a syringe. He further stated that he poured the correct volume from the bottle into a cup and then poured the tube feeding into the syringe and fed via gravity. The surveyor confirmed that no tubing was utilized for the gravity feeding. On 2/12/26 at 10:37 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked how tube feeding should be administered with the use of multidose containers. The DON stated per manufacture guidelines and per resident's orders. The surveyor reviewed the concern that staff were using multidose containers of tube feeding formula to administer tube feeding via syringe. The surveyor asked for the manufacturer's guidelines for Jevity 1.5 Cal, the formula that Resident #1 received. On 2/12/26 at 11:25 AM, the surveyor reviewed the guidelines for Jevity 1.5 Cal. The product description stated the formula could come in two forms, a 235 milliliter can or 1.5 liter ready-to-hang and containers. The can instructions stated that once opened, the can should be covered, refrigerated and used within 48 hours. The ready-to-hang container, the one that was in Resident #1's room, noted failure to follow the instructions for use increase the potential for microbial contamination and may reduce hand times. The instructions stated for gravity feeding, to use a 12 French (a commonly used, moderate-sized medical catheter with an outer diameter of 4.0 mm) or larger tube. The precautions stated to follow directions for the use provided by the manufacture of feeding sets. On review of the facility's policy for Care and Treatment of Feeding Tubes, the surveyor noted the staff was asked to ensure that the selection and use of enteral nutrition was consistent with manufacturer's recommendations. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the review of the policy the surveyor reviewed the concerns with the Director of Nursing (DON) that the facility was not following the manufacturers guidelines and as the instructions stated, increased the risk of microbial growth and contamination. Cross reference F658 2) On 02/08/2026 9:19 AM during the initial pool assessment, it was observed that Resident # 120 had a full bottle of tube feeding formula that was not dated or timed for when the feeding was hung. The bottle did have the tubing attached and was connected to the pump. Next to the formula bottle there was bag of water to flush the tube feeding and it had the date of 02/07/2026. The resident had an order for the tube feeding, via a pump, to run over 12 hours from 6 pm to 6 am.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interviews, facility policy review, and record review, it was determined that the facility failed to provide respiratory care consistent with professional standards for oxygen administration. This was found evident of 1 (Resident #8) out of 2 residents reviewed for respiratory care during the survey. The findings include: Nasal cannula- a medical device used to provide supplemental oxygen therapy to people who have lower oxygen levels. On 2/8/26 at 9:11 AM, the surveyor observed that Resident #8 was utilizing oxygen via nasal cannula. The nasal cannula was attached to an oxygen concentrator (a machine that extracts and filters nitrogen from ambient air to deliver 85-95% pure oxygen). The surveyor noted that 3 liters of oxygen per minute were being delivered to the resident from the oxygen concentrator. Resident #8 stated that he/she was supposed to have 4 liters of oxygen however, the machine was unable to maintain 4 liters and could only be turned as high as 3. On 2/11/26 at 9:08 AM, the surveyor reviewed Resident #8's care plan. The review revealed a care plan was initiated on 12/31/25 that stated, Resident #8 has oxygen therapy related to respiratory illness. One of the interventions written was oxygen setting, Resident #8 has oxygen via nasal (cannula) at (X) liters continuously. No specific concentration of oxygen was noted in the intervention but instead a letter x. On 2/11/26 at 11:48 AM, the surveyor reviewed Resident #8's orders. On 11/5/25 an order was written for Resident #8 to have 4 liters/minute of oxygen via nasal cannula. On 2/12/26 at 11:28 AM the surveyor conducted an interview with Unit Manager (UM) #10. The surveyor showed UM #10 Resident #8's oxygen concentrator and noted it was at 3 liters/minute. When asked what the ordered dose of oxygen was for Resident #8 UM #10 stated she would look it up and follow-up. After returning she stated that the level should be 4 liters/min. UM #10 was not able to increase to 4 liters/min on the concentrator and stated that she would have to replace the machine and that there was a spare machine on site. Next the surveyor reviewed the oxygen administration policy. The policy stated that oxygen should be administered under orders of a physician. It further stated, Resident's receiving oxygen should have a care plan that identifies the intervention for oxygen therapy based on the resident's assessment and orders such as but not limited to the type of oxygen delivery system, continuous or intermittent, when to discontinue, flow rates and SPO2 levels as ordered. Per the facility policy, all elements were not part of Resident #'8s respiratory care plan.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, record reviews, and staff interviews, it was determined that the facility failed to provide appropriate pain management medication for resident 31. This was evident for 1 of 1 residents reviewed for pain management during the recertification surveyOn 2/8/2026 at 9:09 AM, the surveyor interviewed Resident #31. 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. The resident stated that they were not receiving their pain medication correctly. 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. Further review of the medical record on 2/12/2026 at 9:12 AM revealed that on the Medication Administration Record that on 2/11/2026 the 6:00 AM dose was not signed for indicating that the dose had not been given. Hydrocodone-Acetaminophen 7.5-325mg is a controlled regulated substance that each tablet is signed for when it is administered. The control substance record did not have a tablet signed out on 2/11/2026 at 6:00 AM and the count for Hydrocodone-Acetaminophen 7.5-325 mg was accurate further proving that the medication had not been given. The Assistant Director of Nursing (ADON) was notified of the medication error.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with facility staff and family, it was determined that the primary medical provider failed to review the total program of care when the plan when a code status changed. This was found evident for 1 (Resident #1) out of 44 residents selected for review during the survey. The findings include: On [DATE] at 8:19 AM, the surveyor reviewed Resident #1's paper medical record. The review revealed a MOLST dated [DATE] that indicated Resident #1 wanted CPR based on instructions in the patient's advanced directives. On [DATE] at 1:45 AM, the surveyor reviewed a newer MOLST dated [DATE] provided by the DON that indicated Resident #1's surrogate decision maker elected to not have CPR performed in the case of cardiac arrest. The declination was Do Not Intubate (DNI). (This still allows limited ventilatory support by CPPAP or BIPAP). On [DATE] at 8:22 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked for documentation that would reveal the rationale/informed decision conversation that Resident #1's Resident Representative (RP) and Resident #1's primary provider had regarding the change in code status for Resident #1. The DON stated Resident #1 was transferred to the hospital in February 2025 and suggested that the change in code status may have been done at the hospital. She further stated that Resident #1's primary care provider also provides care at the hospital Resident #1 was transferred to. She stated she would look for the provider note that discussed the decision to change in Resident #1's medical regimen. Next the surveyor reviewed Resident #1's progress notes. A note written on 2/2025 by Provider #27 that stated the reason for the progress note was due to a readmission evaluation visit. Nowhere in the note did it state any conversation about changing the code status with Resident #1's RP. The plan stated, continue with plan of care. Again on [DATE] Provider #27 saw Resident #1 and wrote a progress note for a follow-up visit. This was the same day Resident #1's MOLST was changed from a full code to a Do Not Intubate (DNI). No notation that the change in care was ordered. The plan stated multispecialty notes reviewed and laboratory date reviewed with no new medications. On [DATE] at 10:23 AM, the surveyor conducted a phone interview with Provider #28, Resident #1's primary care physician. During the interview the surveyor asked if he had discussions and reviewed the risks and benefits for the change in code status for Resident #1 with Resident #1's RP. Provider #28 stated that he had that discussion and would have to review his notes.Next the surveyor conducted a phone interview with Resident #8's RP. During the interview the RP stated that she agreed with the current MOLST order but could not recall having the provider speak with her about the MOLST on the February 2025 admission. At the time of exit no additional documents were provided to the surveyor.

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	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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on medical record review and interview, it was determined that the facility failed to address medication regimen review (MRR) recommendations made by the consulting pharmacist. This was found to be evident for 2 (#35 and #75) out of 5 residents reviewed during the recertification survey. The findings include:Medication Regimen Review (MRR) is a comprehensive, ongoing, or monthly evaluation of a patient's medication list by a pharmacist to identify, prevent, and resolve medication-related problems. It involves reviewing all prescribed and over the counter medications, nutritional supplements, and lab results for interactions, duplications, inappropriate doses, and adverse effects to improve patient safety. This process is critical in the long-term care settings to maintain safety and reduce the risk of harm related to medication mismanagement. 1) On 02/10/26 at 11:50 AM, the surveyors reviewed Resident #35's MRR, dated 05/28/2025, which stated: Please initiate albuterol MDI 2 puffs every 6 hours PRN for shortness of breath. Wait 1 minute between puffs. Although the MRR recommendation was acknowledged on 06/18/25, it was not implemented. On 02/11/26 at 1:23 PM, the surveyor interviewed the Director of Nursing (DON) regarding Resident #35's MRR. The DON stated that she was unable to find the MRR recommendation follow up for 05/28/2025, and acknowledged that the recommendations were not addressed. 2) The surveyor conducted a record review of Resident #75's medical record on 2/12/2026 at 7:45 AM. Record review revealed that Resident #75 had pharmacist recommendations that had not been acted on by the physician or Director of Nursing (DON). Resident #75 had a physician order for Midodrine 5 mg by mouth 2 times a day for hypotension. Midodrine is used for low blood pressure upon standing (orthostatic hypotension). On 4/23/2025, 5/29/2025 and 7/30/2025 the pharmacist recommended during the monthly MRR that Midodrine should not be given after 6 pm or after the evening meal or less than 4 hours before bedtime. Resident #75 was receiving Midodrine in the evening at 2100 (9:00 PM). This time of 2100 (9:00 PM) was not changed by the facility until 8/5/2025; approximately 3 1/2 months from the initial pharmacist recommendation. Additionally, the pharmacist MRRs on 8/28/2025 and 10/29/2025 revealed that there was not a ferritin, TIBC and TSAT lab documented in Resident #75's medical record. Resident #75 had a physician order for Ferrous Sulfate 325 mg by mouth daily, an iron supplement. The pharmacist made a recommendation on 8/28/2025 and 10/29/2025 that during iron therapy the ferritin, TIBC and TSAT levels should be monitored every 3 months. In an interview with the Director of Nursing (DON) at 11:50 AM on 2/12/2026, the surveyor reviewed the pharmacist DRRs for Resident #75. The DON acknowledged the surveyor regarding the delay in the time change for the Midodrine and the recommendation for lab work (ferritin, TIBC and TSAT) not addressed with a rationale. The DON stated that she would follow up regarding the recommended lab work. In a follow-up interview with the DON on 2/13/2026 at 10:55 AM, she stated that Resident #75 had the iron studies done this morning by Diamond Lab. On 2/13/2026 at 12:30 PM the surveyor reviewed the facility's policy and procedure for Addressing Medication Regimen Review Irregularities implementation date 3/1/2023 and revised date (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/27/2025. The policy indicated that the pharmacist reviews the medication regimen of each Resident at least monthly. Additionally, the policy indicated that if the pharmacist should identify a recommendation the physician shall address the recommendation and the response shall be documented in the Resident's medical record or on a form designated by the facility prior to the next scheduled review. On 2/13/2026 during the survey exit the facility administrative staff were notified of the concerns with the pharmacist drug regimen reviews. No additional information was provided by the facility at the time of exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record reviews and interviews, it was determined that the facility staff failed to adequately monitor a resident's drug regimen which allowed unnecessary duplicate orders for medications. This finding was evident for 1 (Resident #8) of 5 residents reviewed for unnecessary medications during the survey. The findings include: On 2/11/26 at 9:30 AM, the surveyor reviewed Resident #8's medical record. The review revealed trazodone (an antidepressant) was ordered for Resident #8 on 3/19/25 and stated, give trazodone 50mg by mouth at bedtime for depression. On review of the August 2025 Medication administration this was last given on 8/6/25 (the order discontinued on 8/7/25). On further review an additional order for trazodone was written on 8/5/25 and stated, give trazodone 50mg (three tabs to equal 150mg) by mouth nightly for insomnia. On review of the MAR this dose was given on 8/6/25 and 8/7/25 then discontinued on 8/7/25. Trazadone was given twice on 8/6/25 due to duplicate order. The surveyor next reviewed Resident #8's current medication orders. The review revealed an order for Zofran (brand name) also known as Ondansetron. The order was written on 12/24/25 and stated to give 4mg by mouth every 8 hours as needed for nausea/vomiting. This was an active order for Resident #8. Additionally, Ondansetron was ordered on 2/6/26 with instructions to give 4 mg every 8 hours as needed for nausea/vomiting. Two orders were written for the same medications. On 2/11/26 at approximately 1:30 PM, the surveyor conducted an interview with the Assistant Director of Nursing (ADON). During the interview the surveyor reviewed the concerns that Resident #8 had duplicated orders for two medications. The ADON stated she would remove the current duplicate order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews with staff, it was determined that the facility failed to properly store a Resident's medication. This was found evident on 2 of 3 observations for Resident #8. The findings include: On 2/8/26 the surveyor observed that Resident #8 had an inhaler next to him/her. The surveyor asked Resident #8 when the last time he/she used the inhaler. Resident #8 stated that he/she had taken a dose in the night when his/her breathing felt tight. The surveyor noted the inhaler was albuterol (a rapid-acting bronchodilator often called a rescue inhaler, used to treat or prevent bronchospasms) On 2/12/26 at 11:28 AM, the surveyor along with Unit Manager (UM) #10 both observed Resident #8 with his/her albuterol inhaler next to the resident. After leaving the room the surveyor asked UM #10 if Resident #8 was supposed to have medication at the bedside. UM#10 stated Resident #8 did not have an order or assessment completed to ensure self-administration of the inhaler was appropriate. She further stated she would remove the inhaler and pursue the step needed to identify if Resident #8 was safe to self-administer his/her inhaler. Next the surveyor reviewed the policy Resident Self-Administration of Medications. The policy states, a resident may only self-administer medications after the facility's multidisciplinary team has determined which medications may be self-administered safety. The assessment should be recorded in the medication self-administration assessment and kept in the medical record.

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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 interview, observation and record review it was determined that the facility failed to follow up on dental care recommendations. This was found to be evident for 1 (#131) of 1 residents reviewed during the recertification survey. The findings include:On 02/08/26 at 8:40 AM, the surveyor interviewed Resident #131. The resident stated they had no teeth or dentures and had experienced discomfort from chewing on their gums. The surveyor observed the resident had no teeth while they ate breakfast. On 02/10/26 at 8:15 AM, a review of Resident #131's notes revealed dental/oral evaluations from 10/19/25, 01/23/26, and 01/26/26. The evaluations or dental notes did not mention a pending consult. The resident's last appointment was on 08/19/24 for dental extractions. On 02/12/26 at 9:34 AM, a review of Resident #131's dental consultation recommendations from 03/18/2024 stated Please call the attached number (410- -) to schedule dental surgery. The process to start making dentures (5 appointments total) can be done 1-2 months after surgery. On 02/13/26 at 8:11 AM, the Director of Nursing acknowledged the delay in dental care and stated the facility would arrange follow up care.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, an interview and record review the facility failed to maintain proper infection control procedures, specifically regarding staff's use of beard nets in the kitchen. This was evident during the follow-up tour of the kitchen. The findings include: On 2/11/2026 at 12:32 PM Staff #16, the [NAME] entered the kitchen with a hair net, washed their hands and went to the walk-in refrigerator and removed lettuce, tomatoes and ham. Staff #16 put on gloves and began cutting tomatoes, lettuce and ham. On 02/11/2026 at 12:41 PM Staff # 15, the Kitchen Director in Training went over to Staff #16, the [NAME] and assisted them with putting on a beard net. On 2/11/2026 at 2:00 PM Staff #17, the Kitchen Director, was interviewed and asked if it was required for kitchen staff to wear hair and beard nets while in the kitchen. Staff #17 replied yes hair and beard nets are required in the kitchen. Then Staff #17 was informed that Staff #16, the [NAME] was not wearing a beard net to cover their beard while cutting, tomatoes, lettuce and ham. Staff #17 did acknowledge that Staff #16 should have had a beard net on before they began handling any food. On 2/11/2026 at 2:15 PM record review of the facility policy stated that all kitchen staff will have their hair off the shoulders, confined in a hair net or cap and facial hair properly restrained.

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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. Based on facility staff interviews and surveyor record reviews it was determined that the facility failed to maintain Resident medical records that were accurate and reflective of the Residents' care. This finding was found to be evident in 2 (Resident #19 and #126) out of 7 Residents reviewed for Resident records - identifiable information.The findings include: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.Antiplatelet medication is a drug that prevents blood cells called platelets from sticking together to form dangerous blood clots, reducing the risk of heart attacks, strokes, and cardiovascular events. These medications are crucial for patients with coronary artery disease, stent placement, or prior vascular events.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.The surveyor conducted a record review of Resident #19's medical record on 2/10/2026 at 12:15 PM. Review of the medical record revealed that Resident #19 had an active physician order for Clopidogrel 75 mg by mouth daily for anticoagulant, order date 11/22/2025. Clopidogrel was not an anticoagulant medication, but an antiplatelet medication. Additionally, there was a care plan for Resident #19 that addressed monitor signs and symptoms (s/sx) of complications, abnormal bleeding and bruising, related to anticoagulant use.The surveyor at 2:20 PM on 2/10/2026 conveyed to the Director of Nursing (DON) that Resident #19 had a care plan for monitoring s/sx of complications for anticoagulant medication use and was not currently on an anticoagulant. The surveyor asked the DON who was responsible for the implementation and revision of Resident care plans and the DON that it was the responsibility of the clinical team.An Ostomy is a surgically created opening (stoma) on the abdomen that redirects waste (stool or urine) outside the body into a wearable pouching system, used when digestive/urinary systems cannot function normally due to disease, injury, or cancer. 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.The surveyor conducted a record review of Resident #126's medical record at 8:37 AM on 2/11/2026. Review of the medical record revealed that Resident #126 had a care plan for bowel incontinence/ostomy and an intervention for observe and report any redness, inflammation, drainage at ostomy site. Further review of Resident #126's medical record, specifically the MDS assessments Section H revealed that the Resident did not have an ostomy and was incontinent of bowel. Additionally, there was no physician order for ostomy care.In an interview with the Director of Nursing (DON) on 2/11/2026 at 9:45 AM the surveyor conveyed that Resident #126 had a care plan with intervention for ostomy care. The DON confirmed that Resident #126 did not have an ostomy. No additional information was provided by the facility at the time of exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, it was determined that the facility failed to 1) maintain infection prevention control practices for the storage of linen and 2) have a process to identify residents who required transmission based precautions. This was found to be evident in 2 (27 and 112) out of 2 rooms and 1 out of 3 nursing units reviewed for infection prevention and control during the recertification survey. The findings include: 1) At 7:40 AM on 2/11/2026 the surveyor conducted a random observation of the nursing unit. Outside of room [ROOM NUMBER], the nursing unit's clean linen cart was uncovered with folded linen observed on the three shelves of the cart. Additionally, employee #9 was observed administering medications to Residents and 2 Geriatric Nursing Assistants (GNAs) observed removing linen from the clean linen cart but did not cover the linen cart with the plastic pink cover that was attached to the cart. In an interview with employee #24 at 7:50 AM on 2/11/2026, the surveyor showed employee #24 the uncovered linen cart outside of room [ROOM NUMBER]. The surveyor asked employee #24 what the expectation was for covering the linen cart with clean linen on the shelves of the cart. Employee #24 stated that the linen cart should be covered and proceeded to cover the linen cart with the attached pink cover. No additional information was provided by the facility at the time of survey exit. 2) On 02/12/2026 at 11:11 AM the surveyor observed a Contact Precautions sign on the door of room [ROOM NUMBER]. The surveyor asked RN #21 how they identified the resident on Contact Precautions. RN #21 responded that they learned about precautions during shift report and from the sign on the door, and that visitors typically ask them for information. The surveyor asked Staff #26 how they knew which resident was on contact precautions. Staff #26 stated, When a resident is on a contact precautions, the facility places the sign on the door. When the surveyor asked how Staff #26 could identify the resident was on contact precautions, Staff #26 stated they prepped for both and treated them like both were on contact precautions. On 02/13/2026 at 6:57 AM, the surveyor asked GNA #23 how they knew which resident in room [ROOM NUMBER] was on contact precautions. GNA #23 stated, I would talk to the nurse. The surveyor then asked LPN #24 which resident was on precautions. LPN #24 responded, That's a good question. I think it should be Enhanced Barrier Precautions. I will go check. LPN #24 returned moments later and stated, I cannot find a reason for Contact Precautions. I will change it to Enhanced Barrier Precautions (EBP). The surveyor conducted a record review of the facility's Matrix on 02/13/2026 at 8:19 AM, which did not reveal any residents on transmission-based precautions. On 02/13/2026 at 10:19 AM, the surveyor interviewed Infection Preventionist (IP) Staff #3. Staff #3 stated that room [ROOM NUMBER] should probably have EBP and room [ROOM NUMBER] was on Contact Precautions for a wound. The IP stated she performed rounds and assessed the signage on the door. The IP further explained that they did not identify which bed required precautions to protect resident privacy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/13/2026 at 12:21 PM, the Director of Nursing acknowledged the concern during an interview and stated that room [ROOM NUMBER] should probably be on EBP and she would investigate the issue.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and staff interview it was determined the facility failed to assure that a heating unit and oxygen concentrator were fully operational while in use in Resident care areas. This was found evident in 1 (Resident # 122's room) out of 55 rooms reviewed and 1 (Resident #8) out of 2 residents reviewed for oxygenation. The findings included: On 2/8/26 at 9:11 AM, the surveyor observed that Resident #8 was utilizing oxygen via nasal cannula (a tube placed in the nares used to deliver supplemental oxygen). The nasal cannula was attached to an oxygen concentrator (a machine that extracts and filters nitrogen from ambient air to deliver 85-95% pure oxygen). The surveyor noted that 3 liters of oxygen per minute were being delivered to the resident from the oxygen concentrator. Resident #8 stated that he/she was supposed to have 4 liters of oxygen however, the machine was unable to maintain 4 liters and could only be turned as high as 3. On 2/11/26 at 11:48 AM, the surveyor reviewed Resident #8's orders. On 11/5/25 an order was written for Resident #8 to have 4 liters/minute of oxygen via nasal cannula. On 2/12/26 at 11:28 AM the surveyor conducted an interview with Unit Manager (UM)#10. The surveyor showed UM #10 Resident #8's oxygen concentrator and noted it was at 3 liters/minute. When asked what the ordered dose of oxygen was for Resident #8 UM #10 stated she would have to look it up and follow-up. After returning she stated that the level should be 4 liters/min. UM #10 was not able to increase to 4 liters/min on the concentrator and stated that she would have to replace the machine and that there was a spare machine on site. 2 On 2/8/26 at 8:39 AM, the surveyor observed a chair pressed up against Resident #122's wall mounted heating unit. The heating unit was not on and cool air could be felt from the wall. Resident #122 stated that he/she had pushed the chair against the heating unit to prevent the cool air from coming in. He/she further stated that the heating unit stopped working a few days prior and the assistant maintenance worker was aware. On 2/8/26 at 1:28 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA) along with the Director of Maintenance Staff #6. During the interview both staff stated they were unaware of the heating unit not working. Staff #6 confirmed that the wall heating unit was not working and that the unit would be fixed/replaced.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview it was determined the facility failed to 1) ensure a resident had access to the call bell and 2) ensure a call device was accessible in each shower. This was evident for 2 of 3 observations for (Resident #1) and also during the environmental tour of the facility conducted during the recertification survey.The findings include:1) On 2/8/26 at 8:25 AM, the surveyor observed Resident #1's soft touch call bell on the floor next to Resident #1's bed. On 2/8/26 at 8:27 AM, the surveyor conducted an interview with Resident #1's Geriatric Nursing Assistant (GNA) #5. During the interview GNA #5 stated that the call bell must have fallen out of bed when the previous shift repositioned him/her. The surveyor asked GNA #5 if it was expected to check the resident to make sure that they have the call bell in reach before leaving. GNA #5 stated that was her practice. On 2/12/26at 6:22 AM, the surveyor observed GNA #29 providing care to Resident #1. The surveyor also observed the call bell on the ground. On 2/12/26 at 6:57 AM, the surveyor returned to Resident #1's room with his/her nurse Licensed Practical Nurse (LPN) #25. Resident #1's call bell remained on the floor. GNA #29 was no longer in the room. LPN #25 also noted the call bell on the floor and stated the call bell must have fallen out when the GNA was providing care earlier. LPN #25 returned the call bell to Resident #1. 2) A tour of the facility on 2/10/2026 at 10:10 AM with the Maintenance Director revealed the shower facility on Station 1 was without a call device system. The Maintenance Director provided no additional information.

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility failed to maintain a safe, functional, sanitary and comfortable environment for the residents, facility staff and the public. This was found to be evident in the facility reviewed for a safe, functional, sanitary and comfortable physical environment.The findings include:1a. On 2/8/26 at 8:16 AM, the surveyor made an observation in room [ROOM NUMBER] and noted that the hand sanitizer in room [ROOM NUMBER] was not able to dispense any hand sanitizer. On 2/8/26 at 8:20 AM, the surveyor walked into room [ROOM NUMBER] and again the hand sanitizer would not dispense. On 2/8/26 at 8:28 AM, the surveyor conducted an interview with Geriatric Nursing Assistant (GNA) #5. During the interview GNA #5 confirmed that the hand sanitizer in room [ROOM NUMBER] was not working and stated that on Friday she told housekeeping about it. The surveyor also informed GNA #5 of room [ROOM NUMBER]'s hand sanitizer not working. On 2/8/26 at 9:19 AM, the surveyor observed that room # 16's hand sanitizer was not dispensing as well. On 2/8/26 at 1:44 PM, the surveyor interviewed the Nursing Home Administrator (NHA) and the Director of Maintenance Staff #6. During the interview the surveyor reviewed the 3 observations of hand sanitizers not dispensing. Staff #6 stated that both maintenance and housekeeping are responsible for attending to wall hand sanitizers. He stated maintenance reviews the batteries and housekeeping monitors the levels. The NHA stated that housekeeping should be refilling the hand sanitizers each week. Both staff confirmed that hand sanitizers should be functioning 1b . On 2/8/26 at 9:20 AM, the surveyor interviewed Resident #36. During the interview the surveyor noted a draft coming from the window next to Resident #36's bed. Resident #36 stated that when it was windy outside that a draft can be felt. Resident #36 further stated a few days ago, one of the pictures that was kept on the windowsill, blew off onto the floor. The surveyor observed the dust on the blinds blowing from the draft. Also noted were watermarks on the blinds. On 2/8/26 at 1:38 PM, the surveyor observed the window with the Nursing Home Administrator (NHA) and Director of Maintenance Staff #6. Both the NHA and Staff #6 confirmed the draft from the window. Resident #36 reported to the NHA and Staff #6 that when it rains water comes through the window. Staff #6 stated that he would call a window repair contractor in to evaluate how to fix the window. 2. On 2/10/2026 at 1:45 PM the surveyor made a random observation of the facility's public bathroom that was used by Residents, facility staff and the public. The ceiling tile in this bathroom was observed stained with a large brown color. This was observed by the survey team throughout the survey. On 2/13/2026 at 6:56 AM the Licensed Nursing Home Administrator (LNHA) was notified of the concerns with the facility regarding the physical environment. At the exit conference on 2/13/2026 the administrative staff was notified of the concerns with the facility regarding a safe, functional, sanitary, comfortable environment.

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

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation, it was determined that the facility failed to keep the premises free of pests. This deficient practice had the potential to impact all residents. The findings include: On 02/08/26 at 8:40 AM, the surveyors interviewed Resident #131 and they stated I see roaches in my room all of the time. On 02/08/26 at 10:02 AM, the surveyors observed a dusty pest trap under the wall mounted ventilation unit, cobwebs, and a dead spider on the window in room [ROOM NUMBER].On 02/10/26 at 9:01 AM, the surveyors observed a bug crawling on the floor near Station 1. On 02/10/26 at 9:03 AM, the surveyor interviewed LPN #10, who stated there have been roach sightings throughout the facility. On 02/13/26 at 11:40 AM, the surveyors interviewed the Administrator, who acknowledged the pest control concerns.