STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215326	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Summit Park	1502 Frederick Road Catonsville, MD 21228

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on resident interview, observations, and staff interviews, it was determined the facility failed to maintain a homelike environment. This was evident in 2 (Room A21 and Room D18) out of 9 rooms reviewed for environment. The findings include:1.) On 8/12/2025 at 8:12 AM, During an interview with Resident #4, the resident stated that their bathroom sink had no working hot water. This surveyor observed the bathroom sink to only have the hot-water faucet handle to functioning. When opening the cold-water faucet handle there was no water coming out of the faucet. This surveyor made the Unit manager on the A-wing (Staff #2) aware of the findings. On 8/15/2025 at 2:15 PM, this surveyor asked the Director of Nursing (DON) about the progress of the malfunctioning water faucet in Resident #4's bathroom. The DON stated they were not aware but would address the concern.On 8/18/2025 at 2:44 PM, This surveyor verified with observation that the sink is now functioning. Furthermore, an interview was conducted with the Maintenance Director (Staff #20) and stated that on Friday 8/15/2025 a call to a plumber was made because the resident's pipe was clogged. Staff #20 confirmed that the plumber fixed the issue by replacing pipe that same day. 2.) On 8/26/2025 at 9:43 AM, an observation and interview was conducted with Resident #52. Resident #52 stated that the curtains in the room were always dusty and that staff was not cleaning them appropriately. The resident stated that there were black dots all over the door frame of the bathroom. This surveyor confirmed the resident's concerns and obtained photographs of the areas. The curtain on the window had large pieces of dust and white particles. The black dots on the door frame started on the top of the frame and extended to the wall above the door frame.On 8/26/2025 at 10:40 AM, an interview was conducted with the Maintenance Director (Staff #20). This surveyor expressed Resident #52's concerns about the Black dots and Dusty curtains. Staff #20 stated they will address dust and particles on the curtains and the black dots on the wall and bathroom door frame.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and interviews, it was determined that the facility failed to ensure that residents were provided with summaries of their baseline care plans including a list of their medications. This was evident for 1 (Resident #15) of 3 residents reviewed for baseline care plans.The findings include:On 8/14/2025 at 10:32 AM A Review of Resident #15's medical record was conducted. The review indicated that the resident was admitted on [DATE] and a baseline care plan was completed on 1/24/25. However, the electronic copy of the baseline care plan had no signatures that indicated the resident had reviewed or was provided a summary of the baseline care plan. On 8/14/2025 at 10:52 AM The Director of Nursing (DON) was asked to provide evidence that a summary of baseline care plan was provided to Resident #15. On 8/14/2025 at 11:38 AM An interview with the social worker was conducted. The social worker reported that the facility did not have evidence that the baseline care plan summary was provided to the resident. She further stated that the current facility process was to document a progress note to indicate that the baseline summary was reviewed and provided to residents. On 8/14/2025 at 11:48 AM Further review of Resident #15's progress notes failed to show any documentation that a baseline care plan summary was provided to the resident. The social worker confirmed that there was no note on the resident's file that addressed baseline care plan. On 8/14/2025 at 11:52 AM Administrator and the DON were made aware of the concerns.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and staff interview, it was determined the facility failed to develop an individualized care plan for 1) a resident receiving oxycodone and 2) a resident with an indwelling foley catheter . This was evident for 2 (Resident #12 and Resident #125) out 20 residents reviewed for care planning. The Findings Include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) On 8/27/2025 at 9:03 AM, a review of Resident #12’s care plans was conducted. No care plan addressing Oxycodone (an opioid used to treat pain) was found. On 8/27/2025 at 9:31 AM, a review of Resident #12’s medication orders were conducted. The resident was ordered 1 Oxycodone 10 mg oral tablet to be given orally every 6 hours as needed for pain. On 8/27/2025 at 9:46 AM, a review of the Medication Administration Record for the month of August for Resident #12 was conducted. The resident received the oxycodone 10 mg tablet twice a day for 24 days in August 2025. On 8/27/2025 at 10:16 AM, an Interview was conducted with the Director of Nursing DON. When asked who is responsible for creating care plans, the DON stated that the unit managers, supervisors, and Minimum Data Set Nurse are responsible for creating the care plans and inputting them into the chart. When asked if there should be a care plan addressing oxycodone for Resident #12 in place, the DON agreed that if Resident #12 is ordered Oxycodone that there should be a care plan addressing that order along with monitoring interventions. 2) On 08/21/2025 at 9:44 AM, a review of medical records revealed that the resident was admitted [DATE] to the facility, from a hospital, with an indwelling foley catheter. On 08/21/2025 at 9:45 AM a review of the baseline care plan, completed on 4/15/2025, revealed that the resident had a foley catheter. On 8/21/2025 at 9:47 AM a review of the admission MDS, completed on 4/21/2025, under section H (Bowel and Bladder) indicated that the resident had a foley catheter. On 8/21/2025 at 9:50 AM a review of the resident’s care plans revealed that the facility failed to implement a focus area, goals, and interventions for the indwelling foley catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/2025 at 12:02 PM during an interview with the director of social work (Staff #17), she confirmed that the resident did not have a care plan for the indwelling foley catheter. At this time she was made aware of the concern. On 8/21/2025 at 12:20 PM the Director of Nursing was made aware of the concern and again on exit on 8/27/2025.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record reviews and interviews, it was determined that the facility failed to ensure that residents received treatment and care to promote the highest practicable wellbeing as evidenced by 1) failure to follow physician orders and 2) failure to provide toileting hygiene for residents who were incontinent of bowel and bladder. This was evident for 3 (Resident #88, #126, and #137) out of 5 residents reviewed for quality of care during the recertification survey. The findings include:1) On 8/12/2025 at 11:24 AM Resident #88 was observed with redness around the left eye. When asked what happened to his/her eye, the resident answered that they fell last week. On 8/12/2025 at 11:30 AM An observation of Resident #88's room was conducted. An opened pack of regular briefs was observed in the bathroom and on top of the resident's dresser. Additionally, the resident showed the surveyor that they wore regular briefs at that time. On 8/12/2025 at 12:44 PM A review of Resident #88's medical record was conducted. The review revealed orders that stated Resident #88 should 1) wear Hipster Padded Brief q shift while awake for fall interventions and 2) float heels when the resident is in bed. Further review of the resident's record indicated that S/He was care planned to wear hip padded briefs every shift and float heels when in bed. On 8/13/2025 at 10:52 AM Resident #88 was observed without any hipster padded briefs. On 8/14/2025 at 7:00 AM Resident #88 was observed sleeping in bed, heels were not floated. On 8/14/2025 at 7:30 AM A review of resident's medical records indicated that the resident was wearing hip padded briefs on 8/12/25 and 8/13/25. Additionally, there was documentation that the resident had heels floated on 8/13/25. On 8/14/2025 at 8:10 AM Another observation was conducted with the surveyor and Staff #5. Staff #5 confirmed that the resident was not wearing hipster padded brief and heels were not floated. On 8/14/2025 at 8:13 AM An interview with the staff #5 was conducted. Staff #5 stated that she inaccurately documented that the hipster padded briefs were worn and the heels were floated. On 8/14/2025 at 11:10 AM The Director of Nursing (DON) was made aware of the concerns.2a) On 8/14/2025 at 10:45 AM A review of confidential complaints reported to the state agency revealed Complaint #330006. The complaint alleged that Resident #137 did not get their diaper changed on December 1st, 2023. On 8/14/2025 at 10:55 AM An interview with the complainant was conducted. They reported that the facility staff did not change Resident #137's diaper during various shifts. On 8/25/2025 at 9:00 AM Review of record revealed that Resident #137 was admitted into the facility on [DATE] and was discharged on 12/07/2023. Review of resident's MDS section H indicated that the resident was coded as always incontinent for bowel and bladder. Also, MDS section GG revealed that the resident was coded as dependent on staff for toileting hygiene.Further review of Resident #137's care plan indicated that the resident needed assistance with toileting and that they were dependent on staff.On 8/25/2025 at 9:20 AM The DON was asked to provide records for toileting hygiene provision for Resident # 137 for November 30th and December 1st.On 8/25/2025 at 10:10 AM Facility provided documentation for bladder and bowel incontinence for [DATE]th and [DATE]st. Review of these documents revealed no documentation on bowel and bladder incontinence for November 30th night shift 11-7. There was documentation that the resident received dressing and bladder incontinence care December 1st at 14:19.On 8/25/2025 at 10:29 AM An interview with the DON was conducted. He stated that he would expect toileting hygiene documentation if bowel and bladder incontinence care was provided to a resident. The surveyor notified the DON that this was a concern that will be taken back to the office. 2b) On 8/21/2025 at 9:45 AM A review of confidential complaints reported to the state agency revealed Complaint #330065. The complaint alleged that residents at the facility had poor hygiene. The complainant reported that Resident #126 did not get their diaper changed in a timely manner. On 8/21/2025 at 10:12 AM Review of Resident #126's medical record was conducted. The review revealed that the resident was admitted into the facility on 5/10/24 and was discharged to the hospital on 2/16/25. Further review of the records revealed MDS completed and accepted on 11/16/24 that indicated the resident was dependent on staff for toileting hygiene, oral hygiene, shower/bathe and personal hygiene. Also, MDS Section H for Bowel and Bladder indicated that the resident was always incontinent.On 8/21/2025 at 10:33 AM Facility was asked to provide documentation for bowel and bladder incontinence care provided to the resident for the months of January and February 2025. On 8/21/2025 at 11:05 AM The surveyor received documentation for bowel and bladder incontinence care from the facility for the month of January only. The review of these documents revealed several days in January (1, 3, 6, 8, 25, 26, and 28) that indicated the resident was not available to receive toileting hygiene care. Additionally, there was no documentation on 1/13, 1/20, 1/27, 1/29 and 1/30). However, review of Resident

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and interviews, it was determined that the facility failed to ensure the resident had an identification wrist band on which led to the wrong resident having their blood drawn. This was evident for 1 (Resident #44) of 28 complaints that were reviewed during the annual survey. The Findings Include: On 8/13/25 at 11:39 AM, complaint #330059 was reviewed and it mentioned that the resident had their blood drawn by mistake due to the resident not having an identification wrist band on. On 8/13/25 at 12:15 PM, the complainant was interviewed. They stated that on 12/9/2024, during a visit with the resident, they noticed that there was gauze and tape on the resident's hand. The complainant then asked the resident's roommate what had happened, they informed the complainant that the lab tech had come into their room and drew Resident #44's blood by mistake. The complainant stated that he asked the facility staff what had happened and they were unaware of the incident. The complainant stated that a grievance was then filed. On 08/18/2025, at 11:21 AM, a review of the facility grievances that were filed in December of 2024 revealed that the complainant did report the incident to the facility on [DATE]. The results, after the investigation, substantiated that the lab error did occur and that the resident did not have an armband on at the time the error occurred.On 08/19/2025 at 12:14 PM, during an interview with the Assistant Director of Nursing, she confirmed that the incident had occurred. She stated that, following the facility's investigation into the incident, it was substantiated that Resident #44 did not have an identification wrist band on which led to the wrong resident's blood being drawn. At this time she was made aware of the concern.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on resident interview, record review, and staff interview, it was determined that the facility failed to prevent a significant medication error. This was evident for 2 (Resident #105 and #52) out of 6 resident's review for unnecessary medications. The findings include:1.) On 8/12/2025 at 11:45 AM, a review of Complaint #330061 was completed. The complaint alleged Resident #105 received the incorrect dose of medication.On 8/12/2025 at 12:02 PM, an interview with Resident #105's representative was conducted. The Resident's representative stated in November of 2024, there was a med error.On 8/15/2025 at 10:04 AM, a review of Resident #105's progress notes was conducted. The change of condition note on 11/10/2024 stated that the resident received 2 mg of Clonazepam instead of the ordered 1 mg of Clonazepam. Order was placed to hold the next dose of Clonazepam, vital signs every shift, and to complete neuro checks every 24 hours. On 11/10/2024 at 00:15, the note stated, during med count writer found out that the clonazepam came in 1mg, so one tablet should've been given. Nurse Practitioner notified.On 8/15/2025 at 10:18 AM, a review of Resident #105's Medication Administration Record indicated that Staff #23 was the Licensed Practical Nurse who gave Clonazepam prior to the change of condition note and the order of Clonazepam being held. On 8/15/2025 at 10:49 AM, a review of Resident #105's orders was completed. The clonazepam Oral Tablet 0.5 mg Controlled Drug was ordered to give via G-Tube every 8 hours for seizures on 10/19/24 and discontinued on 11/9/24. The order was revised and stated, PLEASE GIVE ONLY ONE TABLET, on 11/9/24. On 8/15/2025 at 11:05 AM, a review of Facilities investigation was conducted. A statement from Staff #23 states the staff found out the medication was given incorrectly at narcotic count on change of shift on 11/9/2024 at 11:00 PM.On 8/15/2025 at 1:53 PM, an interview was conducted with the Director of Nursing. When asked about the medication error, they stated medication error was confirmed and staff were educated. 2.) 8/26/2025 8:48 AM, a review of Complaint #330032 was conducted. The complaint stated that a nurse gave Resident #52 the wrong medication. The complaint extended from 2/20/2024 to 8/15/2025.On 8/26/2025 at 9:34 AM, a review of Resident #52's progress notes was conducted. In a change of condition note from 3/4/2025 at 5:39 PM, it stated, Med error, administer 4-unit lispro due to wrong identification of resident picture by name. MD and Supervisor was notified. Md recommend q6 b/s monitoring. Vital signs was stable; b/s 107 @ 5.39pm, 113 @ 11.54pm. pt alert x4, No sign of hypoglycemia or hyperglycemia. Non-adverse reactions noted. call light within reach. Family notified.On 8/26/2025 at 11:15 AM, a review of the facilities incident report regarding the medication error was conducted. In the incident report, there was education provided to the Licensed Practical Nurse (Staff #22) who administered the medication to the incorrect resident (Resident #52) on 3/4/2025.On 8/26/2025 at 11:20 AM, an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) was conducted. It was confirmed that Staff #22 made a medication error by not identifying the correct resident and giving a dose of 4 units of Lispro to the incorrect resident. Per the ADON, the nurse was placed back on 3-day orientation after the error and another competency was completed on 3/11/25.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Number of residents sampled: Number of residents cited: Based on record review and interview, it was determined that the facility failed to obtain laboratory tests as ordered by the physician. This was evident for 1 (Resident #120) of 27 residents reviewed during the investigation portion of the survey. The Findings Include: On 08/18/2025 at 7:27 AM, Resident #120's record review revealed a change in condition stating the resident had a change in mental status with paranoid delusions on 6/17/2025. The physician placed an order to obtain a urine analysis (UA) to rule out a possible urinary tract infection on 6/18/2025. On 08/18/2025 at 7:40 AM, a review of the resident's documented lab results revealed that there were no results for the ordered urine analysis. Further review revealed that there was no documentation of refusal. On 08/18/2025 at 1:52 PM, during an interview with the Director of Nursing (DON), he explained that the reason the UA was not obtained was due to the resident refusing. When asked to provide documentation proof of refusal he stated that there was no documentation. At this time, and again at exit on 8/27/2025, the DON was made aware of the concern of the order for the UA not being obtained.