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	06/26/2026

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

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record reviews, and review of facility policy, the facility failed to ensure care was provided in accordance with the written plan of care for two (2) of 24 sampled residents (Resident #3, and Resident #8). Resident #8 did not receive intravenous (IV) fluids as ordered by the physician, and Resident #3 was not provided wound care in accordance with physician's orders. The findings include: 1. On [DATE] at 2:30 PM the facility's Emergency Crash Cart and Automated External Defibrillators (AEDs) policy dated [DATE] was reviewed and noted It is the policy of this facility to ensure that the facility will maintain at least one emergency cart per nursing care floor with additional carts added as deemed necessary in the case of the need for basic life support.Compliance Guidelines: 1. The facility will store the emergency crash cart in a location that is readily accessible.3. Equipment/supplies used from the emergency crash cart are noted and replaced promptly. 4. The emergency crash cart is checked every 24 hours and after every use. Missing or expired items are replaced, when applicable. Review done on [DATE] at 10:00 AM of Resident #8 's clinical record revealed the resident was admitted into the facility on [DATE] with diagnoses that included atherosclerotic heart disease of native coronary artery without angina pectoris, essential hypertension, chronic kidney disease, and chronic systolic (congestive) heart failure. Review done on [DATE] at 10:05 AM of Resident #8's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, and the MDS triggered a care plan for dehydration/fluid maintenance. Review done on [DATE] at 10:15 AM of Resident #8's Progress Notes revealed the following: [DATE] at 5:29 AM Change in Condition – New order for IV hydration. [DATE] at 9:25 AM General Nurses Note – 0925 – patient was observed by this nurse to be in acute distress/discomfort; V/S [vital signs] were obtained to include BP [blood pressure]: 97/54; RR [respiratory rate]: 25 O2 [oxygen]: 96% R/A [room air] temp [temperature] 98.9 tympanic; HR [heart rate] 62 with notable pacer; Patient was re positioned in bed by this nurse and medication aide; and patient was still observed to be in discomfort/acute distress.NP [Nurse Practitioner] 31 - 0959 [9:59 AM] at bedside to assess this pt.[patient] along with [Unit Manager (UM) 8]. Patient was noted to have a BP of 84/47 with RR of 25; UM 5 states there is no IV supplies on the unit, despite a detailed list on the code cart checked by this nurse. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 10:15 AM – Pt VS are currently 93/56, with RR of 28; NP 31 at bedside to coordinate care of this patient with attd [attending] physician; Current plan of care is to obtain STAT Labs and await results pending pt clinical presentation. [DATE] at 1:34 PM Change in Condition Brief Synopsis of Change: Resident observed to be hypotensive with BP 91/52 R 22. Summary of Change of Condition: Resident observed to be hypotensive with BP 91/52 R 22. [DATE] at 1:59 PM – Change in Condition Data: new order for IV hydration Action: completed and will continue to monitor Response: will continue to monitor. Review done on [DATE] at 10:45 AM of Physician's Orders revealed: [DATE] at 5:10 PM – Sodium Chloride Solution .9% - Use 1 liter intravenously one time only for hydration for 1 day rate 75 cubic centimeters (cc)/hour-No flushing required for continuous therapy. Observe Site for signs/symptoms (s/s) of infiltration/extraction at a frequency based on therapy and resident condition. Last ordered [DATE] and End [DATE] at 5:09 PM. [DATE] at 5:45 PM – Insert Midline for IV hydration one time only for IV hydration for 1 day. Review done on [DATE] at 9:45 AM of the Medication Administration Record (MAR) from [DATE] through [DATE] revealed that IV fluids were administered on [DATE] at 10:13 AM, the day after the order was initiated from NP #31. Observation on [DATE] at 11:15 AM, the surveyor, accompanied by UM 5, observed the crash cart on Unit D, and reviewed the crash cart log to reconcile the item in the cart matched what was indicated on the log. The log indicated that all required items were checked and present for [DATE]; however, upon opening the crash cart and auditing each compartment item by item, there were three (3) missing supply categories, as follows: 1. IV starter kits (3 missing) 2. Primary IV tubing (1 missing) 3. IV catheters (3 missing) in varying sizes These items were not present despite being marked as available on the crash cart checklist for the date of the observation just as the IV starter kit was not available on the morning of [DATE] when NP #31 ordered for Resident #8 to receive IV fluids. Interview on [DATE] at 12:15 PM with UM 5 who was a Licensed Practical Nurse (LPN) on D Unit revealed the nurse recalled that Resident #8 admitted into the facility from the hospital and had several comorbidities and issues with dehydration and low blood pressure. UM 5 said that on [DATE], an agency nurse was assigned to care for Resident #8. UM 5 said that he/she could not recall the exact orders NP #31 gave that day for Resident #8. When asked about where the IV starter kit was to be kept, UM 5 said there should have been an IV starter kit in the emergency crash cart, and one in a box in the medication room. UM 5 said that Resident #8's assigned nurse may not have looked in the right place for the IV starter kit on that day. UM 5 did not recall who started Resident #8's IV that day; and said that the facility's Assistant Director of Nursing (ADON) took over Resident #8's care once (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the assigned nurse was removed from providing care for R#8. During an interview on [DATE] at 2:20 PM, UM 8 said that Resident #8's assigned (agency) nurse notified him/her in trying to reach NP #31 because the agency nurse felt that Resident #8 was not stable and needed to go to the hospital. UM 8 said the resident's vitals were taken and the resident's blood pressure was low. UM 8 said that they were not sure about whether the IV starter kit was available in the crash cart and said that it should have been. UM 8 said he/she left the area and went back to his/her unit after NP #31 gave their orders. Interview on [DATE] at 3:55 PM with the facility's Assistant Director of Nursing (ADON) said that they did not start the IV per NP #31 order and was not aware if the IV starter kit was on the crash cart. The ADON said that a third-party company came in and started Resident #8's IV because nursing staff in the building was unable to do so. The ADON was not aware of when the IV was started. Interview with NP #31 on [DATE] at 1:38 PM revealed that the NP gave verbal orders for STAT labs and IV fluids on the morning of [DATE] for Resident #8. The NP recalled that the agency assigned nurse and UM 8 could not locate an IV starter kit to start the IV fluids. By the time NP #31 left the building the IV had not been started yet. The NP said he/she intended for Resident #8's IV fluids to be started on [DATE]. The NP confirmed that he/she documented the order for IV fluids in Resident #8's record on the afternoon of [DATE] and further stated that he/she thought Resident #8 was receiving the IV fluids at that time. The NP said it was not intended for Resident #8 to start the IV fluids on the following morning, [DATE], and the resident did not receive his/her medication in accordance with physician's orders. 2. Resident #3 was admitted to the facility on [DATE] with diagnoses that included dementia, hypertension, peripheral artery disease, and chronic kidney disease. A review of Resident #3's quarterly Minimum Data Set (MDS), dated [DATE], was conducted on [DATE] at 3:00 p.m. The review revealed the resident had moderate cognitive impairment and a venous/arterial ulcer. A review of Resident #3's care plan, dated [DATE], was conducted on [DATE] at 3:15pm. The review showed Resident #3 had a vascular impairment. The goal was for the wound to show signs of improvement. Interventions included following the wound provider's orders for wound treatment. A review of Resident #3's physician orders, dated [DATE], was conducted on [DATE] at 12:25pm. The review revealed an order for wound care to the right lower medial leg venous wound: clean with normal saline (NS), pat dry, apply calcium alginate, cover with border gauze, and wrap with Kerlix every evening shift. On [DATE] at 12:07 p.m., an observation was conducted of ADON3 performing wound care on Resident #3's right lower extremity. ADON3 performed hand hygiene, donned personal protective equipment (PPE), removed the old border gauze dressing, cleansed the wound with normal saline, patted it dry with gauze, applied calcium alginate to the wound bed, covered it with an abdominal pad, and wrapped it with Kerlix. The dressing applied did not follow the physician's order, which required border gauze rather than an abdominal pad. On [DATE] at 3:59 p.m., an interview was conducted with ADON3. She/he stated the order was not followed because another nurse had read the order, and she/he believed the treatment applied (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	matched the written order. ADON3 stated, I should have read the order myself. On [DATE] at 3:49 p.m., an interview was conducted with the Director of Nursing (DON). She/he stated it was expected that ADON3 should have checked the wound order herself/himself. The DON stated she/he would provide inˆservices to ADON3 and the rest of the nursing staff.