STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue Baltimore, MD 21206

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record reviews and staff interviews, it was determined that the facility failed to review and revise the care plan after each Minimum Data Set (MDS) assessment known as required . This was evident for 1 (Resident #32) out of 2 residents selected for Dialysis review during the survey.Findings include:The Centers for Medicare & Medicaid Services (CMS) defines the Minimum Data Set (MDS) as a standardized, comprehensive assessment of all residents in Medicare or Medicaid-certified nursing homes and swing beds. It is a tool used to gather information on resident strengths and needs, develop individualized care plans, and is used for Medicare/Medicaid reimbursement and quality of care. Section N (High-Risk Drug Classes) of the MDS, is used to document the resident's medication status for injections, high-risk drug classes, and medication-related problems.On 11/20/2025 at 11:40 AM during record review of resident #32, the resident Care Plan (dated 9/11/25) revealed Resident is on Anticoagulant therapy related to cardiac disease process; Date Initiated: 06/06/2023; and Revision on: 09/15/2025. However, further record review revealed no current anticoagulant therapy orders. The resident's last anticoagulant therapy (Heparin) was ordered on 10/15/24 and discontinued 2/4/25; the Care Plan was not updated to reflect this change, despite the MDS properly reflecting the change during 3 cycles of reviews.On 11/20/2025 at 12:08 PM during record review of resident #32, this Surveyor reviewed the Minimum Data Set (MDS), Section N (High-Risk Drug Classes), which is used to document the resident's medication status for injections, high-risk drug classes, and medication-related problems. It revealed an answer of ?Yes' indicating that the resident was receiving Anticoagulant therapy on the 9/13/24: Annual and 12/14/24: Quarterly assessments. Additionally, after the Heparin orders were discontinued on 2/4/25, the MDS, Section N was then answered ?No' during the 3/16/25: Quarterly, 6/16/25: Quarterly, and 9/14/25: Annual assessments for Anticoagulant therapy.On 11/21/2025 at 12:21 PM during an interview with LPN Unit Manager staff # 14 and MDS Coordinator staff #23, when asked who is responsible for discontinuing or updating the resident care plan, MDS Coordinator staff #23 stated the unit manager is responsible for updating the Care Plan with any changes. The Surveyor then asked, how are medication orders and care plan changes monitored; the Unit Manager staff #14 stated orders are ran every 24hrs by the Unit Manager and Care Plan discussions and updates are done weekly on the unit. When asked if this Care Plan accurately reflected the current Anticoagulant therapy, the Unit Manager staff #14, agreed No.

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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(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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on record reviews and staff interviews, it was determined that the facility failed to adhere to professional standards of quality of care based on established clinical practices, physician orders, or facility policies regarding enteral feeding and medication administration. This was evident for 4 residents (Residents #9, #210, #208 and #117) out of 4 residents reviewed for professional standards of quality care during the survey. Findings include:Professional standards of quality relate to the requirement that services provided in a long-term care facility must heavily involve proper medication administration practices. This regulation is part of the Centers for Medicare & Medicaid Services (CMS) guidelines for nursing homes, and citations often occur when facilities fail to adhere to established clinical practices, physician orders, or facility policies regarding medications. Facilities must ensure that all care and services, including medication administration, adhere to accepted standards of clinical practice. This is often interpreted through established guidelines like the six rights of medication administration: right patient; right medication; right dose; right route; right time; and right documentation. 1. During observation rounds on 11/17/25 at 9:00 AM, Resident #9's tube feeding bottle was observed hanging at the bedside. The bottle was unlabeled, with no documented rate of infusion and no time indicating when it had been hung. The feeding was not running, yet the tubing remained connected to the resident's PEG site, posing a risk for contamination. When interviewed, staff #6 were unable to provide the time the feeding was started or the intended rate. Review of the facility's policy titled Care and Treatment of Feeding Tubes requires that feeding tubes be utilized in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Current standards require enteral feeding containers to be labeled with start time, rate, and resident identifiers, and that non-running feedings be disconnected to prevent contamination. These requirements were not followed. 2. On 11/20/2025 at 10:07 AM, the surveyor reviewed complaint #333113. Complaint #333113 indicated that Resident #210's medication was not administered timely. On 11/24/2025 at 3:14 PM, the surveyor reviewed Resident # 210's medical records which revealed that Resident #210's Medication Admin Audit Report indicated that the resident received the following morning medications late on 10/1/25: Hydralazine HCl 100 MG Oral Tablet, for hypertension, was scheduled for 6:00 AM and was administered at 1:21 PM; and Gabapentin 600 MG Oral Tablet, for burning in bilateral lower extremities, was scheduled for 6:00 AM and was administered at 1:21 PM. On 11/24/2025 at 3:34 PM, the surveyor interviewed staff #2. During the interview, the surveyor asked staff #2 what the expectation of staff is when administering medication to residents. Staff #2 stated that the expectation is that staff administer medication to residents either one hour before the medication is scheduled or one hour after medication is scheduled. 3. On November 19, 2025, at 2:45 PM, the surveyor spoke with Resident #208's wife who explained how she was upset with the facility for double-dosing her husband for 14 days. The wife explained how Resident #208 was very drowsy and looked sedated when she came to visit them. The wife was notified by the methadone program at the hospital of their denial to refill the methadone medication too soon after 12/30/24. The wife continued to explain how she had asked the nurses several times (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	why Resident #208 was looking like that (sedated), but received no response. On 11/24/25 at 1 PM, the surveyor spoke with the Director of Nursing (DON) #2 and the Regional DON #17 about what happened with Resident #208 and their methadone dosage. The DON #2 explained that the methadone had come from the program with 2 doses in each bottle, and because the nurses were used to having a single dose in each bottle, the nurses proceeded to give them a whole bottle as their dosage instead of splitting the bottle in half. The DON #2 was asked if any grievance had been filed. The DON #2 stated yes, there was a grievance filed and completed. The surveyor asked for a copy of the grievance. The DON #2 was asked when she was made aware of the error with the medication. The DON #2 explained that she was asking for a refill on the methadone from the Methadone Clinic when the methadone was denied for being too soon for a refill. It was then deduced that a medication error had been made and that the resident had received the wrong dosage of methadone. From 11/21/24 to 12/4/24, the resident was receiving 102 mg of methadone twice a day. When the DON #2 was asked if there were any negative outcomes or adverse reactions identified with this medication error. The DON #2 responded, no. The surveyor then asked for copies of the Medication Error filed, the letter that was sent to the Methadone Clinic, the Medication Administration Records (MAR) for the methadone during November 2024, December 2024, and January 2025, and the Chain of Custody Record for each methadone order. Review of the Grievance Form revealed that on 1/2/25, Resident #208's wife complained that Resident #208 was receiving too much methadone over the last 2 weeks. The grievance was investigated by the DON #2, who concluded that a review of the resident's medication administration record should be completed and that accurate dosing and adherence to physician orders. No negative outcomes or adverse reactions were identified. The resident remained stable, and their medication regimen would continue to be monitored to ensure effectiveness and safety. The facility communicated with the prescribing methadone clinic to ensure medication packaging supports safe administration and reduces the risk of medication errors. Staff education was completed, and the methadone prescription was refilled per the physician's orders to ensure uninterrupted treatment and prevent any lapse in pain management or withdrawal symptoms. Review of the Licensed Nurse Administration Record revealed that the resident started the first dose on 11/20/24 at 10 AM. The initial order was transcribed as Methadone HCL Oral Solution 10 MG/5ML, give 25ml by mouth two times a day for opioid disorder, and should have lasted until 12/16/24. It was discontinued at 11:31 AM on 11/20/24. The next transcribed order stated Methadone HCL Oral Solution 10 MG/5ML, give 10 mL by mouth two times a day for substance abuse. Hold for systolic B/P less than 110 on dialysis days. May give after dialysis and was started on 11/20/24 at 6 PM, and again should have lasted until 12/16/24. It was noted on the Licensed Nurse administration Record that the resident did not miss any doses from 12/16/24 through to 12/30/24; however, the facility only received 14 bottles for use from 11/20 to 12/16/24. Which would have made the methadone last until 12/3/24. The resident would not have had enough to last from 12/4/24 through to 12/16/24, and especially not through to 12/30/24 when the next refill was requested. It was also identified that the perimeters given for the systolic Blood Pressure were not being followed as the order was written. Medication was to be held for any Systolic Blood Pressure less than 110. On the following 8 dates, these instructions were not met: 12/14, 12/19, 12/20, 12/21, 12/25, 12/28/24 and 1/11/25, and 1/20/25. The methadone was not held or any note written that the provider was notified of the low systolic blood pressure. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Chain of Custody Record revealed that the facility had received 28 doses of Methadone to be used from 11/20/24 to 12/16/24. The record also states that there is 102 mg (1st dose split) in each bottle, with 14 bottles received. It was documented on the form that Resident #208 was receiving one dose a day from 11/21/24 to 12/16/24. However, Resident #208 only signed off on 11/20/24 through to 12/2/24 that they received the methadone. From 12/3/24 through 12/16/24, the form was only documented by the nurse giving the methadone with no resident sign-off. The next chain of custody record was not until 12/31/24, with the dosage split into separate bottles for the AM and PM dosage as requested by the DON #2 to the Methadone Program. 4. 11/18/2025 8:15 AM during initial observation and interview with resident #117, a medication cup with approximately 30 mL of light-yellow liquid was observed on the bedside table. When this Surveyor asked the resident what it was, the resident stated oh, this was my medicine I had to take; the resident was unable to state the name or reason of the medication. During this encounter, CMA Staff #15 came to the resident door peering in during our interaction; the Surveyor asked the staff member, while pointing to the medicine cup, what medication was left at the bedside, staff #15 stated that was Lactulose. Staff #15 also stated the resident does not take all of the medications at once; I come back periodically until the resident takes them all. Surveyor then went to the Medication Cart with staff #15, it was in the Dining Hall directly across from Resident #117's room; however, the cart was away from the entrance of the door and out of view of the resident. While at the medication cart with staff #15, the Surveyor observed the medication administration record of Resident #117 with staff #15, it revealed a medication time to be given of 10:00 AM and order for Lactulose Oral Solution 10 GM/15ML (Lactulose) Give 30 ml by mouth one time a day for Hepatic Encephalopathy. This order was not charted as given, despite being left unattended by staff at bedside, prior to the Surveyor's 8:15 AM observation; nearly 2 hours prior to the medication ordered time. On 11/18/2025 at 11:00 AM during interview with Director of Nursing staff #2 and Nursing Home Administrator staff #1, this Surveyor notified them of the observed medication at bedside left unattended by CMA staff #15 and the early administration. When asked if medications were ok to leave at bedside for residents to take on their own and the early timing, both the DON and NHA stated No.

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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 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 staff interviews, interviews with the family, and record review, it was determined that the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs, such as those in excessive dosage or given for an excessive duration. This was evident for 1 (Resident #208) out of 1 resident reviewed for unnecessary drugs.The findings include:On November 19, 2025, at 2:45 PM, the surveyor spoke with Resident #208's wife regarding the complaint intake. Resident #208's wife explained how she was upset with the facility for double-dosing her husband for 14 days. The wife explained how Resident #208 was very drowsy and looked sedated when she came to visit them. The wife was notified by the methadone program at the hospital of their denial to refill the methadone too soon after 12/30/24. The wife continued to explain how she had asked the nurses several times why Resident #208 was looking like that (sedated), but received no response. On 11/24/25 at 1 PM, the surveyor spoke with the Director of Nursing (DON) #2 and the Regional DON #17 about what happened with Resident #208 and their methadone dosage. The DON #2 explained that the methadone had come from the program with 2 doses in each bottle, and because the nurses were used to having a single dose in each bottle, the nurses proceeded to give them a whole bottle as their dosage instead of splitting the bottle in half. The DON #2 was asked if any grievance had been filed. The DON #2 stated yes, there was a grievance filed and completed. The surveyor asked for a copy of the grievance. The DON #2 was asked when she was made aware of the error with the medication. The DON #2 explained that she was asking for a refill on the methadone from the Methadone Clinic when the methadone was denied for being too soon for a refill. It was then deduced that a medication error had been made and that the resident had received the wrong dosage of methadone. From 11/21/24 to 12/4/24, the resident was receiving 102 mg of methadone twice a day.When the DON #2 was asked if there were any negative outcomes or adverse reactions identified with this medication error. The DON #2 responded, no. The surveyor then asked why Resident #208 had been found on the floor in their room on 11/21/24 and 11/23/24. The DON #2 explained that Resident #208 stated that they had lost their balance and slid down to the floor in front of their bed. The DON #2 was asked if the resident might have fallen because he/she was drowsy from the double-dosing of methadone. The DON #2 was unsure and stated, no. The surveyor then asked for copies of the Medication Error filed, the letter that was sent to the Methadone Clinic, the Medication Administration Records for the methadone during November 2024, December 2024, and January 2025, and the Chain of Custody Record for each methadone order. On 11/24/25 at 12:30 PM, revealed that in the progress notes, it was noted that Resident #208 had a fall on 11/21/24 and then again on 11/23/24. The progress noted did not explain in detail the condition of the resident or why they had fallen on those 2 days. Review of the Grievance Form revealed that on 1/2/25, Resident #208's wife complained that Resident #208 was receiving too much methadone over the last 2 weeks. The grievance was investigated by the DON #2, who concluded that a review of the resident's medication administration record should be completed and that accurate dosing and adherence to physician orders. No negative outcomes or adverse reactions were identified. The resident remained stable, and their medication regimen would continue to be monitored to ensure effectiveness and safety. The facility communicated with the prescribing methadone clinic to ensure medication packaging supports safe administration and reduces the risk of medication errors. Staff education was completed, and the methadone prescription was refilled per the physician's orders to ensure uninterrupted treatment and prevent any lapse in pain management or withdrawal symptoms.Review of the Licensed Nurse Administration Record revealed that the resident started the first dose on 11/20/24 at 10 AM. The initial order was transcribed as Methadone HCL Oral Solution 10 MG/5ML, give 25ml by mouth two times a day for opioid disorder, and should have lasted until 12/16/24. It was discontinued at 11:31 AM on 11/20/24. The next transcribed order stated Methadone HCL Oral Solution 10 MG/5ML, give 10 mL by mouth two times a day for substance abuse. Hold for systolic B/P less than 110 on dialysis days. May give after dialysis and was started on (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/20/24 at 6 PM, and again should have lasted until 12/16/24. It was noted on the Licensed Nurse administration Record that the resident did not miss any doses from 12/16/24 through to 12/30/24; however, the facility only received 14 bottles for use from 11/20 to 12/16/24, which would have made the methadone last until 12/3/24. The resident would not have had enough to last from 12/4/24 through to 12/16/24, and especially not through to 12/30/24 when the next refill was requested.Review of the Chain of Custody Record revealed that the facility had received 28 doses to be used from 11/20/24 to 12/16/24. The record also stated that there was 102 mg (1st dose split) in each bottle, with 14 bottles received. It was documented on the form that Resident #208 was receiving one dose a day from 11/21/24 through to 12/16/24. However, Resident #208 only signed off on 11/20/24 through to 12/2/24 that they received the methadone. From 12/3/24 through 12/16/24, the form was only documented by the nurse giving the methadone with no resident sign-off. The next chain of custody record was not until 12/31/24, with the dosage split into separate bottles for the AM and PM dosage as requested by the DON #2 to the Methadone Program.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, interviews with the family, and record review, it was determined that the facility failed to ensure that residents were free of any significant medication errors. This was evident for 1 (Resident #208) out of 1 resident reviewed for medication errors.The findings include:On November 19, 2025, at 2:45 PM, the surveyor spoke with Resident #208's wife regarding the complaint intake. Resident #208's wife explained how she was upset with the facility for double-dosing her husband for 14 days. The wife explained how Resident #208 was very drowsy and looked sedated when she came to visit them. The wife was notified by the methadone program at [NAME] of their denial to refill their methadone too soon after 12/30/24. The wife continued to explain how she had asked the nurses several times why Resident #208 was looking like that (sedated), but received no response.On 11/24/25 at 1 PM, the surveyor spoke with the Director of Nursing (DON) #2 and the Regional DON #17 about what happened with Resident #208 and their methadone dosage. The DON #2 explained that the methadone had come from the program with 2 doses in each bottle, and because the nurses were used to having a single dose in each bottle, the nurses proceeded to give them a whole bottle as their dosage instead of splitting the bottle in half. The DON #2 was asked if any grievance had been filed. The DON #2 stated yes, there was a grievance filed and completed. The surveyor asked for a copy of the grievance. The DON #2 was asked when she was made aware of the error with the medication. The DON #2 explained that she was asking for a refill on the methadone from the Methadone Clinic when the methadone was denied for being too soon for a refill. It was then deduced that a medication error had been made and that the resident had received the wrong dosage of methadone. From 11/21/24 to 12/4/24, the resident was receiving 102 mg of methadone twice a day.When the DON #2 was asked if there were any negative outcomes or adverse reactions identified with this medication error. The DON #2 responded, no. Review of the Grievance Form revealed that on 1/2/25, Resident #208's wife complained that Resident #208 was receiving too much methadone over the last 2 weeks. The grievance was investigated by the DON #2, who concluded that a review of the resident's medication administration record should be completed and that accurate dosing and adherence to physician orders. No negative outcomes or adverse reactions were identified. The resident remains stable, and their medication regimen will continue to be monitored to ensure effectiveness and safety. The facility communicated with the prescribing methadone clinic to ensure medication packaging supports safe administration and reduces the risk of medication errors. Staff education was completed, and the methadone prescription was refilled per the physician's orders to ensure uninterrupted treatment and prevent any lapse in pain management or withdrawal symptoms.Review of the Licensed Nurse Administration Record revealed that the resident started his first dose on 11/20/24 at 10 AM. The initial order was transcribed as Methadone HCL Oral Solution 10 MG/5ML, give 25ml by mouth two times a day for opioid disorder, and should have lasted until 12/16/24. It was discontinued at 11:31 AM on 11/20/24. The next transcribed order stated Methadone HCL Oral Solution 10 MG/5ML, give 10 mL by mouth two times a day for substance abuse. Hold for systolic B/P less than 110 on dialysis days. May give after dialysis] and was started on 11/20/24 at 6 PM, and again should have lasted until 12/16/24. It was noted on the Licensed Nurse administration Record that the resident did not miss any doses from 12/16/24 through to 12/30/24; however, the facility only received 14 bottles for use from 11/20 - 12/16/24. Which would have made the methadone last until 12/3/24. The resident would not have had enough to last from 12/4/24 through to 12/16/24, and especially not through to 12/30/24 when the next refill was requested.Review of the Chain of Custody Record revealed that the facility had received 28 doses to be used from 11/20/24 to 12/16/24. The record also states that there is 102 mg (1st dose split) in each bottle, with 14 bottles received. It was documented on the form that Resident #208 was receiving one dose a day from 11/21/24 through to 12/16/24. The next chain of custody record was not until 12/31/24, with the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dosage split into separate bottles for the AM and PM dosage as requested by the DON #2 to the Methadone Program.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, interviews with the family, and record review, it was determined that the facility failed to ensure that medical records and forms were complete and accurately documented. This was evident for 3 (Resident #208, Residents #213, and Resident #214) out of 3 resident reviewed for medical records.The findings include:1. On November 19, 2025, at 2:45 PM, the surveyor spoke with Resident #208's wife regarding the complaint intake. Resident #208's wife explained how she was upset with the facility for double-dosing her husband for 14 days. The wife explained how Resident #208 was very drowsy and looked sedated when she came to visit them. The wife was notified by the methadone program at [NAME] of their denial to refill their methadone too soon after 12/30/24. The wife continued to explain how she had asked the nurses several times why Resident #208 was looking like that (sedated), but received no response. On 11/24/25 at 1 PM, the surveyor spoke with the Director of Nursing (DON) #2 and the Regional DON #17 about what happened with Resident #208 and their methadone dosage. The DON #2 explained that the methadone had come from the program with 2 doses in each bottle, and because the nurses were used to having a single dose in each bottle, the nurses proceeded to give them a whole bottle as their dosage instead of splitting the bottle in half. The DON #2 was asked if any grievance had been filed. The DON #2 stated yes, there was a grievance filed and completed. The surveyor asked for a copy of the grievance. The DON #2 was asked when she was made aware of the error with the medication. The DON #2 explained that she was asking for a refill on the methadone from the Methadone Clinic when the methadone was denied for being too soon for a refill. It was then deduced that a medication error had been made and that the resident had received the wrong dosage of methadone. From 11/21/24 to 12/4/24, the resident was receiving 102 mg of methadone twice a day. Review of the Licensed Nurse Administration Record revealed that the resident started the first dose on 11/20/24 at 10 AM. The initial order was transcribed as Methadone HCL Oral Solution 10 MG/5ML, give 25ml by mouth two times a day for opioid disorder, and should have lasted until 12/16/24. It was discontinued at 11:31 AM on 11/20/24. The next transcribed order stated Methadone HCL Oral Solution 10 MG/5ML, give 10 mL by mouth two times a day for substance abuse. Hold for systolic B/P less than 110 on dialysis days. May give after dialysis and was started on 11/20/24 at 6 PM, and again should have lasted until 12/16/24. It was noted on the Licensed Nurse administration Record that the resident did not miss any doses from 12/16/24 through to 12/30/24; however, the facility only received 14 bottles for use from 11/20 - 12/16/24. Which would have made the methadone last until 12/3/24. The resident would not have had enough to last from 12/4/24 through to 12/16/24, and especially not through to 12/30/24 when the next refill was requested. Review of the Chain of Custody Record revealed that the facility had received 28 doses to be used from 11/20/24 to 12/16/24. The record also states that there is 102 mg (1st dose split) in each bottle, with 14 bottles received. It was documented on the form that Resident #208 was receiving one dose a day from 11/21/24 through to 12/16/24. However, Resident #208 only signed off on 11/20/24 through to 12/2/24 that they received the methadone. From 12/3/24 through 12/16/24, the form was only documented by the nurse giving the methadone with no resident sign-off. The next chain of custody record was not until 12/31/24, with the dosage split into separate bottles for the AM and PM dosage as requested by the DON #2 to the Methadone Program. 2. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage form (CMS-10055) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue Baltimore, MD 21206

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provides information to residents/beneficiaries that services may no longer be covered by Medicare and addresses the resident's liability for payment should they wish to continue receiving the skilled services.The Notice of Medicare Non-coverage form (CMS-10123) informs the beneficiary of his/her right to file an appeal of the decision and the right to an expedited review of Medicare non-coverage of services. On 11/18/2025 at 11:00 AM, the Entrance Conference worksheet: Beneficiary Notice – Residents discharged Within the Last Six Months form was provided to the facility. The facility completed the form and indicated that the following residents were discharged to home, residents #213 on 8/7/25 and resident #214 on 9/17/25. On 11/24/2025 at 11:00 AM, a review of the SNF Beneficiary Protection Notification Review form (CMS-20052) completed by the facility for resident #213 revealed: Medicare Part A Skilled Services Episode Start Date: 6/24/25; Last covered day of Part A service: 8/7/25; and How was the Medicare Part A Service Termination/Discharge determined?: Other (explain): Resident discharged to hospital 8/7/25. On 11/24/2025 at 2:00 PM during record review of resident #213 it revealed two discharge to home notes. A Social Service Note (dated 8/7/25 at 13:18), noted Discharge summary: [resident] is discharging home this date into [their spouse's] care. [The resident] is to receive home health services from [name of home care agency] to include pt(physical therapy), ot(occupational therapy) and skilled nursing. [The resident] has all recommended equipment at home including oxygen. [The resident] is to return to [name of medical provider] on a M, W, F 2nd shift 10:00 a.m. schedule. [The resident] should follow up with [their] primary care physician within 2 weeks of discharge. The Nurse Note (dated 8/7/24 at 14:49), noted 'Resident discharged home today with spouse at 2:43 PM. Discharge paper and prescriptions given to spouse. Resident had no pain or discomfort upon leaving.' 3. On 11/24/2025 at 11:05 AM, a review of the SNF Beneficiary Protection Notification Review form (CMS-20052) completed by the facility for resident #214 revealed: Medicare Part A Skilled Services Episode Start Date: 6/27/25; Last covered day of Part A service: 9/17/25; and How was the Medicare Part A Service Termination/Discharge determined?: Other (explain): Resident discharged to hospital 9/17/25. On 11/24/2025 at 2:05 PM during record review of resident #214 it revealed two discharge to home notes. The Discharge Summary note (dated 9/17/25 at 16:02), revealed 'Patient discharged to home at 330pm. Daughter picked patient up on w/c. All scripts and discharge instructions given to daughter. Patient left facility in stable condition'. The Social Service Note (dated 9/17/25 at 16:18), revealed Discharge summary: [The resident] discharged home this date in the care of [their] daughter who transported [them] home. [The resident] will be living with [their] son who will be provided 24/7 supervised assistance. Home health services will be provided by [name of home care agency]. [The resident] received a wheelchair from [medical equipment provider name]. [The resident] should follow up with PCP within 2 weeks of discharge. On 11/24/2025 at 2:35 PM, during interview with the Nursing Home Administrator (NHA) staff #1, the Surveyor informed NHA staff #1 that the SNF Beneficiary Protection Notification Review (CMS-20052) (continued on next page)

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	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue Baltimore, MD 21206

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forms for residents #213 and #214 indicated the residents were discharged to the hospital despite the record review for both residents and conference worksheet: Beneficiary Notice – Residents discharged Within the Last Six Months form indicating the residents were discharged home. In response the NHA staff #1 stated 'my MDS Coordinator completed the form and likely put the wrong discharge information, the residents were discharged to hospital, let me look into it'. On 11/24/2025 at 4:05 PM during a follow-up interview with NHA staff #1, the Surveyor asked for further information regarding the discharge. The NHA staff #1 stated there is no other information, the residents were discharged home.

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	215330	A. Building B. Wing	11/24/2025

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Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue Baltimore, MD 21206

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews with staff and residents' families, and review of Complaints, it was determined that the facility failed to 1.) ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public; 2.) provide enough clean linen to all residents; and 3.) ensure repairs were made to a resident door and the hallways hand railings. This was evident for 5 (333137, 333135, 333139, 333141 and 333113) out of 5 complaint intakes; 2 (residents #11 and #140) out of 2 residents; and the hallway railing on the third-floor dementia unit observed for sanitary conditions during the survey. The findings include:1. On 11/20/2025 at 10:07 AM, the surveyor reviewed complaint #333113 which alleged that the facility did not have enough linen for all residents. On 11/24/2025 at 12:40 PM, the surveyor interviewed Staff member #18. During the interview, staff #18 mentioned that the facility does not have enough blankets for all the residents, and that the facility is currently in the process of ordering more blankets for the residents. On 11/24/2025 at 12:45 PM, the surveyor conducted observation rounds. During observation rounds, after the clean linen was distributed to the units, the surveyor observed only 2 blankets on the clean linen cart in the laundry room. 2. On 11/18/25 at 3:00 PM, a resident family member told surveyors that the facility was dirty and nasty and that they needed to do better with cleaning and caring for the residents. On 11/21/2025 at 1:15 PM, review of complaint intakes (#333137, #333135, #333139, and #333141) all stated that the facility was outdated, smelled foul, and was dirty. Observations during initial entrance found the facility was not well-lit, and the walls, baseboards, and railings in the hallways were dirty with old stains and spots. There were areas in the hallways that smelled of urine. The surveyor also observed that there weren't any chairs in some of the residents' rooms for visitors to sit in. On 11/24/25 at 12:32 PM, the surveyor observed that the wall behind Resident #11's bed was stained with a substance that ran down the wall. It appeared to have been there for some time; it was dry-looking. The surveyor interviewed the unit manager, Staff #9, starting with showing her the wall behind Resident #11's bed, and she acknowledged that it was something that Resident #11 had thrown on the wall. Staff #9 stated that she would have it cleaned immediately. Continued observations showed that the whiteboard at the nurse's station had black areas around the base of the whiteboard from where the black markers were being used, and the wall was also dirty with marks all around it. The surveyor notified the unit manager of the appearance of the wall around the whiteboard and the appearance of the residents' room doors with heavy impressions of scratches. 3. On 11/18/2025 at 09:08 AM the surveyor observed areas of linoleum flooring behind the third-floor clinical unit's nursing station with brown rust like stained materials, and several mis-matched linoleum pieces, as well as missing pieces of linoleum near the entrance to sitting area of the nursing station. On 11/20/2025 at 12:20 PM the surveyor observed the hand railings between rooms [ROOM NUMBERS] showed peeling paint. (continued on next page)

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	215330	A. Building B. Wing	11/24/2025

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 11/21/2025 at 10:22 AM the surveyor observed a red biohazard bag inside a carboard box on the floor; dirty linen uncovered with personal resident clothing items. In the clean utility room, the surveyor observed that there were no paper towels in the towel container near the sink and there were O2 tanks both full and empty in holders on the left side of the wall, an old call bell and cord were lying on the floor. On 11/24/2025 at 4:13 PM the surveyor interviewed the housekeeping director, staff #19 regarding the environmental issues found on the third-floor clinical unit. Staff #19 stated that he does not have a schedule for stripping waxing the linoleum floors in the facility. Additionally, staff #19 stated that facility perform deep cleaning of resident rooms monthly but did not provide any documentation to support this statement. Staff #19 stated that facility utilizes the TELS system to document and report environmental issues to the housekeeping and maintenance departments. These deficiencies were discussed with the DON and Administrator prior to and during the exit conference on 11/24/2025.