

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5009 Frankford Avenue Baltimore, MD 21206	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of a closed medical record and all pertinent administrative records, and staff interview, it was determined that the facility failed to have a system in place to ensure clinical records were complete and accurately documented. This was found to be evident for 1 (Residents #1) of 3 residents reviewed during a complaint survey. The findings include: Documentation is an integral part of medication administration. Documentation communicates the timing, dosing, and effect of any medications received by a patient. In the setting of skilled nursing care, residents are often prescribed multiple medications for significant medical conditions. They are also often more vulnerable to medication errors and more prone to changes in condition that require review and adjustment of their medication regimen. Inaccurate medication documentation has the potential to place residents at significant risk of medication error, provide incomplete or inaccurate information for providers and care givers to evaluate, and represents a failure of basic medication administration principles. Resident #1 was admitted to the facility on [DATE] after spending a couple days in the hospital being treated for cardiac symptoms. Resident #1 was discharged from the facility on 12/31/25. During a review of complaint 2685115 on 01/20/26 at 12:30 PM, the nurse surveyor requested the Director of Nurses to please ask the medical records to bring for review all of Resident #1's closed paper documents and access to Resident #1's electronic medical record. The facility Director of Medical records presented the nurse surveyor with a folder indicating it held the closed medical records and documents for Resident #1. During the review of Resident #1's closed medical record documents, it was discovered that several of the documents being reviewed were the closed medical records for Resident #3. In an interview with the facility Director of Medical Records (Staff #3) on 01/20/26 at 1:07 PM, Staff #3 stated the documents in Resident #1's closed medical record documents is what s/he received for the staff from the nursing unit and that Resident #1's closed record has not been officially deemed closed because the documents are not in a red folder.</p>

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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