STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215097	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Catonsville	16 Fusting Avenue Catonsville, MD 21228

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review, and interviews, it was determined that the facility failed to accurately document a discharge Minimum Data Set (MDS) assessment in a Resident's medical record. This was found evident of 1 (Resident #135) of 60 residents reviewed in the survey. The findings include: On 8/11/25 at 1:47 PM, the surveyor reviewed Resident #135's medical record. The review revealed that Resident #135 was admitted to the facility in late September 2023 as a hospice respite patient.Further review revealed that on both 9/29/23 and 10/2/23 a progress note was written that described Resident # 135 being found in the sitting position on the floor next his/her bed. In both notes Resident #135 was assessed for injury. On 8/12/25 at 11:23 AM, the surveyor reviewed Resident #135's September and October 2023's Medication Administration Record (MAR). The review revealed that Resident #135 had two pain medications ordered and both were ordered as needed. The review also revealed no documentation to indicate either the Tylenol or Morphine were given. The orders were written for Tylenol 650mg to be given every 6 hours as needed and Morphine 5mg to be given every 4 hours as needed for pain.Next the surveyor reviewed Resident #135's discharge MDS assessment. The review revealed that Resident #135 was documented as having no falls since admission in section J1800. On further review of section J Resident #135 was documented as receiving a scheduled pain medication regimen in section J0100. On 8/12/25 at 1:06 PM, the surveyor conducted a phone interview with the MDS Coordinator, Staff #26. During the interview Staff #26 stated Resident #135 had documented falls and that the no falls was an error and needed a modification to correct the error.On 8/12/25 at 1:53 PM, the surveyor conducted a follow-up phone interview with Staff #26. During the interview Staff #26 confirmed that Resident #135 did not receive scheduled pain medications and the documentation was incorrect and was documented in error.

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 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. Based on record review, facility policy and interviews, it was determined that the facility failed to adequately document wounds and responses to treatment of skin conditions. This was found evident of 1 (Resident #138) of 2 residents reviewed for wounds. The findings include: On 8/14/25 at 11:58 AM, the surveyor reviewed Resident #138's medical record. The review revealed that Resident #138 had a past medical history of peripheral vascular disease and foot pain. On further review it was noted that the facility identified a change of condition on 12/5/23. The change in condition was related to a new open wound on Resident #138's Left Lower Extremity (LLE). A skin assessment was done and noted Resident #138 had a vascular wound to his/her LLE. Nowhere in the change of condition or the skin assessment was the wound's size or characteristics documented. An order for wound care was written to on 12/5/23 for wound care that included, cleaning the wound, and applying a xeroform and kerlix wrap daily to the LLE. The next skin assessment was completed on 12/13/23 and again there was no documentation of the wound size or characteristics to the LLE vascular wound nor any indication that other wounds were present. On 12/14/23 two change of conditions were noted for Resident #138 regarding wounds. The first change of condition was written at 4:46 PM, about a new wound found on his/her right leg. The summary stated, the Resident's right leg dressing was wet and had a foul smell, and that the Resident's pain was reported 8/10. It further stated that there were generalized open areas noted on the right leg and in-between the toes. On the 2nd change of condition written at 11:36 PM, also referenced the new right lower leg wound, but also the previous wound on the LLE. The summary stated, the dressing on bilateral (both) lower extremities were soaked with serosanguinous drainage and had a foul smelling odor. It further stated that Resident #138's right 2nd two had drainage and was black in color. The plan stated was to send Resident #138 to the hospital per family's request. On 8/13/25 at 1:27 PM, the surveyor conducted an interview with the Regional Director of Nursing (RDON). During the interview the surveyor relayed the concern that if the skin condition/wound was not documented with characteristics and/or measurements weekly then how can the facility measure or know if the treatment is working or appropriate or if the wound is getting worse. The RDON agreed that the wound documentation did not have documentation of a full assessment and would look to see if there was additional documentation. The surveyor requested the facility's wound care policy Next the surveyor reviewed the policy titled, Documentation of Wound Treatments. Guide line number 2 stated, the following elements are documented as part of a complete wound assessment: a, type of wound, b, stage of wound, c, measurement , and d, description of wound characteristics. At the time of exit no additional wound assessment was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined the facility staff failed to utilize an appropriate pain assessment based on a Resident's cognitive status. This was evident for 1 (Resident # 135) of 4 residents reviewed for pain. The findings include: On 8/11/25 at 1:47 PM, the surveyor reviewed Resident #135's medical record. The review revealed that Resident #135 had a past medical history that includes, but not limited to, abnormal weight loss and senile degeneration of the brain. He/she was admitted to the facility in late September 2023 as a hospice respite patient. A progress note dated 9/29/23 at 8:44 AM, documented that Resident #135 was very confused while awake and not easily redirected. On 8/12/25 at 11:23 AM, the surveyor reviewed Resident #135's September and October 2023's Medication Administration Record (MAR). The review revealed that Resident #135 had two pain medications ordered and both were ordered as needed. The review also revealed no documentation to indicate either the Tylenol or Morphine were given. The orders were written for Tylenol 650mg to be given every 6 hours as needed and Morphine 5mg to be given every 4 hours as needed for pain. Both September and October MARs had a pain monitoring section. Instructions given were asked; 1a. able to communicate;1b. Are you free of pain or hurting? If no, indicate response through chart code; PI. An additional comment stated, if new or changes in pain, complete pain evaluation, to be done every day shift. Resident #135's documentation of pain monitoring was as follows:9/28/23- 19/29/23-19/30/23-110/1/23-010/2/23-1 On 8/12/25 at 12:06 PM, the surveyor interviewed the Regional Director of Nursing (RDON). During the interview the surveyor asked what the number referenced in Resident #135's pain monitoring documentation. Specifically when it was documented that Resident #135 was confused and not able to communicate appropriately. The RDON stated the PI was Pain Indicator and stated she would look to see if there was a pain code. She further stated she would look to see Resident #135's pain evaluations to see how Resident #135's pain was assessed. The surveyor reviewed the pain assessments with the RDON. On 9/29/23 Resident #135's pain evaluation documented yes to, appears different than usual behavior and indicated that Resident #135 had 10 out of the 13 behaviors listed as pain indicators. The next question asked. Can the resident indicate location and characteristic of pain? No was answered. On 10/2/23 a pain interview assessment was completed for Resident # 135. In the instructions it stated, complete pain assessment interview if the resident is able to communicate appropriately. If the resident is rarely or never understood, skip to section F.The assessment indicated the pain assessment interview should not be completed. On review of section F, titled, Indicator of pain or possible pain, the question is asked, should the staff assessment for pain be conducted? The answer was no and no additional assessment for pain was completed. The surveyor reviewed the concern that Resident #135 was not appropriately assessed for pain on the pain assessment dated [DATE], when it was asked if the resident or staff interview should be completed and both questions were answered no. Additionally, there was no basis provided for the daily pain assessments numbers that were documented on the MARs. The surveyor asked for the pain policy. Next the surveyor reviewed the policy titled, Pain Management. In the section, Pain Assessment #1 states, the facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. In the monitoring section the policy states that facility staff will reassess resident's pain management at established intervals for effectiveness and or adverse consequences. On 8/12/25 at 2:18 PM, the surveyor reviewed the Controlled Drug Administration Records with the Assistant Director of Nursing (ADON) for Resident #135. During the review it was noted that 6 doses of Morphine were taken. The ADON confirmed that a pain assessment should have been completed every time the Morphine was given and a re-assessment should have been completed after to evaluate effectiveness. At the time of exit no additional pain assessments were provided to the surveyor. Cross Reference F755

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of consult services, and interviews it was determined that the facility failed to administer medication according to procedures that assure accurate dispensing of medications. This was found evident in 2 (Resident #135 &#137) out of 7 residents reviewed for medication regimen review. The findings include:1a) On 8/11/25 at 1:47 PM, the surveyor reviewed Resident #135's medical record. The review revealed that Resident #135 was admitted to the facility in late September 2023 as a hospice respite patient.On 8/12/25 at 11:23 AM, the surveyor reviewed Resident #135's September and October 2023's Medication Administration Record (MAR). The review revealed that Resident #135 did not have any as needed pain medications documented as administered or any as needed anxiety medications documented as administered. Resident #135 had orders for Tylenol 650mg every 6 hours as needed for pain, Morphine 5mg every 4 hours as needed for pain and Lorazepam 0.5mg every 4 hours as needed for anxiety. On 8/12/25 at 1:58 PM, the surveyor reviewed the hospice visit notes for Resident #135. The note revealed that the hospice staff made an on-call visit to assess comfort after Resident #135 fell. The note stated that the last morphine given was at noon and that two other doses had been administered since the Resident #135 was admitted . The note stated that the hospice staff collaborated with the facility nurse and that both Morphine and Lorazepam were administered during her visit. Next the surveyor requested the Controlled Drug Administration Records for Resident #135. On 8/12/25 at 2:18 PM, the surveyor reviewed the Controlled Drug Administration Records with the Assistant Director of Nursing (ADON). During the review it was noted that 6 doses of Morphine were taken and 3 doses of Lorazepam were taken for Resident #135. The surveyor reviewed the concern that medications that were taken from the controlled locked medication area and administered however there was no documentation in the Resident's Medication Administration Records to indicate the medication was administered. The ADON confirmed that any controlled medication taken should be signed out in the controlled log book as well as the [DATE]b) On 8/12/25 at 11:23 AM, the surveyor reviewed Resident #137's medical record. The review revealed that Resident #137 was admitted to the facility in late August of 2023 and had a past medical history that included, but not limited to, hypertension (high blood pressure), cardiomyopathy (disease of the heart muscle that makes it harder for the heart to pump blood effectively), congestive heart failure (condition where the heart can't pump enough blood to meet the body's needs), pulmonary hypertension (condition that affects the blood vessels in the lungs) and atrial fibrillation (heart rhythm disorder). On further review of Resident #137's Medication Administration Record (MAR) for September 2023 and October 2023 it was noted that several medications were coded as (4) vitals signs out of perm, (5) hold/see nursing notes, (9)- other /see nurse notes. The findings are as follows:Metoprolol Succinate Extended Release (for heart failure) 9/16/23 coded (4), and 9/29/23 coded (9)Spironolactone (for heart failure) 9/25/23 coded (4)Torsemide (for heart failure) 9/4/23 coded (9), 9/25/23 coded (4)Sildenafil Citrate (for pulmonary hypertension) 9/3/23 coded (9), 9/6/23 coded (5), 9/29/23 coded (5), 9/30/23 coded (5) 10/1/23 coded (9), 10/2/23 coded (5), and 10/3/23 coded (9).Jardiance(for Diabetes Mellitus) on 9/14/23- not given with a comment awaiting delivery.Torsemide on 10/3/23- not given with a comment on order.The surveyor reviewed the medication orders. No medication gave instruction to hold medication according to parameters. On 8/12/25 the surveyor interviewed the Regional Director of Nursing (RDON). During the interview the surveyor relayed the concern that on multiple occasions Resident #137 did not receive his/her medications as ordered and there were no parameters within the medications orders to indicate the medication should be held. The RDON stated that some of the medications held were related to the Resident's blood pressure and it was done by nursing judgement. The surveyor asked if a resident's medication was held without parameters if it would be the expectation for the staff to notify the provider? The RDON stated that she would practice that way and was not able to say if the provider was notified of the medications being held. On 8/14/25 at 10:34 AM, the surveyor interviewed Physician #27. During the interview the physician stated he would expect to be notified if a medication was not being given. He further stated that if medications were recommended by a resident's specialist physician he would be responsible for coordinating medication regimens and need to be aware of medications being held. Cross Reference F697

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	215097	A. Building B. Wing	08/18/2025

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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 record reviews, and interviews, it was determined that the facility failed to: 1) maintain medical records in accordance with acceptable professional standards and practices by keeping complete documentation and 2) file documents in the correct resident's medical record. This was found evident for 2 (Resident #132 and #135) of 60 sampled residents, and for 1 (Resident #6) of 1 resident chart reviewed for change in condition documentation during the recertification survey.The findings include: 1) On 8/11/25 at 12:32 PM, the surveyor reviewed Resident #132’s medical record. The review revealed that Resident #132 had a past medical history that included, but not limited to, acute respiratory failure with hypoxia, sleep apnea, and thrombotic pulmonary embolism. On further review an order was written on 3/27/23 that stated, oxygen at 2 liters per minute via nasal cannula continuously. Next, the surveyor reviewed Resident #132’s vital signs. On 3/26/23, 3/27/23, 3/28/23, 3/29/23, 3/30/23, 3/31/23, 4/1/23, 4/2/23, 4/3/23, 4/4/23, 4/5/23, 4/7/23, 4/11/23, 4/12/23, 4/13/23,4/14//23, 4/15/23, 4/17/23, 4/18/23, 4/19/23 and 4/20/23 a pulse oxygen saturation reading was recorded with a comment indicating that the reading was taken while the resident was on room air, meaning no supplemental oxygen. On 8/11/25 at 1:12 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor relayed the concern that Resident #132 had an order for continuous oxygen and that 21 of the 28 days he/she was at the facility the documentation indicated that he/she was not receiving oxygen while getting his/her vitals taken. The DON stated she believed that the documentation of room air was an error and would follow-up. On 8/11/25 at 1:52 PM, the surveyor conducted a follow-up interview with the DON. During the interview the DON stated she spoke to several of the nurses that documented the vital signs. She confirmed that the documentation of room air was an error and the Resident #132 was on oxygen. On 8/11/25 at 1:42 PM, the surveyor reviewed Resident #135’s medical record. The review revealed that Resident #135 was admitted to the facility in late September 2023 as a hospice respite patient. On 8/12/25 9:33 AM, the surveyor conducted an interview with the Director of Nursing DON. During the interview the surveyor asked for the hospice documentation for Resident #135 or any notes related to the hospice visits. The DON stated that all the documents should be part of the closed record and if the hospice staff had come their visit notes would be in the medical record. She further stated that because Resident #135 was a respite hospice resident he/she would have only been at the facility for 5 days and may not have had a visit. (continued on next page)

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	215097	A. Building B. Wing	08/18/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor next reached out to the hospice consult provider and on 8/12/25 at 1:58 PM, the surveyor reviewed the hospice visit notes for Resident #135. The note revealed that the hospice staff made an on-call visit to assess comfort after Resident #135 fell. The note stated that the hospice staff collaborated with the facility nurse and that both Morphine and Lorazepam were administered during her visit. However, this visit was not documented in the Resident’s medical record. 2) On 8/13/25 at 8:57 AM, while reviewing Resident #6 paper medical record on Unit C, the surveyor observed Resident #20 documentation in Resident #6's paper medical record. The documentation consisted of an appointment slip for a Urology appointment, a transportation form, and a consultation note. The surveyor asked Registered Nurse (RN) #35 to make copies of the documents. While putting the documents back in Resident #6 chart, RN #35 realized the documents belonged in Resident #20 chart. On 8/13/25 at 9:29 AM, the surveyor reported to the Regional Director of Nursing Resident #20 medical documentation was in Resident #6 paper chart. The Regional Director of Nursing verbalized the staff filed the documentation in the wrong chart.

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	215097	A. Building B. Wing	08/18/2025

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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. Based on observation and interviews and review of contractor records, it was determined that the facility failed to keep a sanitary environment. This was found evident in the conference room, ice machine room, kitchen, laundry room and rehabilitation room during the survey. The findings include: On 8/13/25 at 5:43 AM, the surveyor observed vermin dropping located in the first floor conference room. On 8/14/25 at 6:10 AM, the surveyor reviewed the pest management company treatment documents. The surveyor noted that several recommendations were repeated throughout the treatment reports. The pest management company wrote they observed voids (holes) in the kitchen on 2/24/25, 7/16/25 and 7/25/25. On 7/25/25 the comment stated, one of the voids in the kitchen still needs to be sealed. It also stated broken tiles were found that were holding dirty water in breakage under the floor. The company also commented that this attracts roaches to the area. Additionally the company recommended improving sanitation procedures. This was recommended on 5/29/25, 7/16/25 and 7/24/25. On 7/24/25 the comments stated, poor sanitation throughout the kitchen and dish room area were observed. Due to sanitation conditions, this can create and attract roaches; better cleaning procedures are needed for staff to follow. On 8/14/25 at 7 AM, two surveyors took a tour of the facility. In the first-floor ice room a void in the wall where a plumbing pipe was entering the room was stuffed with steel wool. Additionally, what appeared to be a wet dirty towel was noted under the ice machine. On the back wall behind the machine there was debris, a few cup lids and a facemask on the floor. On 8/14/25 at 7:05 AM, the surveyors observed the kitchen. Several cracked tiles were noted on the floor in the hallway just outside the chemical room. On 8/14/25 at 7:07 AM, the surveyors observed the area under the dishwasher. A lid to a pitcher, a bowel, a piece of wrapper and debris were noted. On further observation vermin droppings were noted. Next the surveyor observed a French fry, wrappers and debris under the sink next to the drain. No French fries were being prepared during this observation On the back wall under the stainless steel preparation table, located next to the oven, there was noted vermin droppings. The surveyor next observed the stainless steel preparation tables in the center of the kitchen. Both tables had water accumulation under them. The farther table had a piece of cut banana under it. No bananas were being prepped during the observations. On 8/14/25 at 7:14 AM, the surveyors observed the laundry area in the basement. Multiple corners of the walls had rusted broken metal trim with what appeared to be holes in them. Multiple sections of tile were broken. On 8/14/25 at 7:16 AM, the surveyors observed a bucket collecting drips from a leaking sink. Tiles were broken under the sink. On 8/14/25 at 7:19 AM, the surveyors observed the clean laundry room. A chain of lint was noted alongside the side wall. Behind a linen cart was a dried spill of brown substance, a bottle cap, a wrapper, and a shoe. On 8/14/25 at 7:23 AM, the surveyors observed the rehabilitation department. Along the entrance wall vermin droppings were noted. Further up the wall a pistachio nut was noted. Debris, plastic cap and a ball were noted under the Air Condition (AC) unit. On 8/14/25 at 11:58 AM, the surveyor reviewed the observations and concerns that the facility had accumulated debris, vermin droppings in multiple areas throughout the facility with poor sanitation practices. Cross Reference F925

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	215097	A. Building B. Wing	08/18/2025

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, pest control management record reviews, facility staff interviews, and an investigation into a complaint, it was determined that the facility failed to have an effective pest control program. This was found evident in 3 out of 3 recurrent recommendations given to the facility by the pest management company, and also evident for Complaint #292313. The findings include: 1) On [DATE] at 5:43 AM, the surveyor observed vermin dropping located in the first floor conference room. On [DATE] at 8:41 AM, the surveyor made the Regional Director of Nursing (RDON) aware of the observations and requested any pest management documentation. The RDON stated she would pass the request on to the Nursing Home Administrator. On [DATE] at 10:36 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor asked how the facility handles pest control. The NHA stated that a pest management company comes and treats the facility weekly. He further stated that each unit has a pest log for documenting any concerns and the pest management company checks these books each time they come. The NHA stated that any recommendation the pest management company has is communicated verbally to someone at the facility. On [DATE] at 10:48 AM, the surveyor reviewed the pest log from the A wing nursing unit. Staff did not report any concerns [DATE] through April of 2025, two in May, and two in June. All reports were for bugs (ants, beetles, roaches) and each time the pest management company responded with treatments. On [DATE] at 6:10 AM, the surveyor reviewed the pest management company treatment documents. The surveyor noted that several recommendations were repeated throughout the treatment reports. On [DATE] and [DATE], [DATE] and [DATE] it was recommended the facility utilize the unit log books. Specifically on [DATE] it was written; spoke with nursing that moving forward sightings need to be documented in pest control log books, however, after this it was recommended again on [DATE]. Additionally, the pest management company observed voids (holes) in the kitchen on [DATE], [DATE] and [DATE]. On [DATE] the comment stated, one of the voids in the kitchen still needs to be sealed. It also stated broken tiles found that were holding dirty water in breakage under the floor. Also commented this attracts roaches to the area. The third recommendation was to improve sanitation procedures. This was recommended on [DATE], [DATE] and [DATE]. On [DATE] the comments stated poor sanitation throughout the kitchen and dish room area were observed. Due to sanitation conditions, this can create and attract roaches; better cleaning procedures are needed for staff to follow. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 7 AM, two surveyors took a tour of the facility. In the first floor ice room a void in the wall where a plumbing pipe was entering the room was stuffed with steel wool. Additionally, what appeared to be a wet dirty towel was noted under the ice machine. On the back wall behind the machine there was debris, a few cup lids and a facemask on the floor. On [DATE] at 7:05 AM, the surveyors observed the kitchen. Several cracked tiles were noted on the floor in the hallway just outside the chemical room. On [DATE] at 7:07 AM, the surveyors observed the area under the dishwasher. A lid to a pitcher, a bowel, a piece of wrapper and debris were noted. On further observation, vermin droppings were noted. Next the surveyor observed a French fry, wrappers and debris under the sink next to the drain. No French fries were being prepared during this observation On the back wall under the stainless steel preparation table, that was located next to the oven, was noted vermin droppings. The surveyor next observed the stainless steel preparation tables in the center of the kitchen. Water accumulation was noted under both tables. The farther table had a piece of cut banana under it. No bananas were being prepped during the observations. On [DATE] at 7:14 AM, the surveyors observed the laundry area in the basement. Multiple corners of the walls had rusted broken metal trim with what appeared to be holes in them. Multiple sections of tile were broken. On [DATE] at 7:16 AM, the surveyors observed a bucket collecting drips from a leaking sink. Tiles were broken under the sink. On [DATE] at 7:19 AM, the surveyors observed the clean laundry room. A chain of lint was noted alongside the side wall. Behind a linen cart was a dried spill of brown substance, a bottle cap, a wrapper, and a shoe. On [DATE] at 7:23 AM, the surveyors observed the rehabilitation department. Along the entrance wall vermin droppings were noted. Further up the wall a pistachio nut was noted. Debris, plastic cap and a ball were noted under the Air Condition unit. On [DATE] at 11:58 AM, the surveyor reviewed the observations and concerns that the facility was not following the recommendations of the pest management company and that the facility had an ineffective pest control program. Cross Reference F921 2) The Office of Healthcare Quality (OHCQ) is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland’s health care facilities and community-based programs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215097	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Catonsville	16 Fusting Avenue 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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor investigated Complaint #292313 on [DATE] at 7:15 AM that was filed with the Office of Healthcare Quality (OHCQ) on [DATE] at 10:36 AM by Resident #143’s family. The complainant reported that the facility staff left a mouse on the trap for 10 hours in the Resident’s room before removing it after a request for it to be removed from the Resident’s room. Resident #143 was admitted to the facility for short term rehabilitation on [DATE] and discharged home on [DATE]. At 8:00 AM on [DATE], the survey team observed mouse droppings behind the credenza in the conference room. The Licensed Nursing Home Administrator (LNHA) was notified at 12:00 PM; observed these mouse droppings; acknowledged the surveyors and stated that the contracted pest control company services the facility on a weekly basis. The surveyor conducted a record review on [DATE] at 2:15 PM of the All State Pest Management Service Inspection Reports for the months of [DATE] and [DATE]. All State Pest Management was the contracted company that serviced the facility for pest control. On the [DATE] visit, the technician “inspected and treated all 4 nurses’ stations for occasional invaders; inspected and treated activity room for prior mice activity; deceased mouse was found under the refrigerator during the visit”. On the [DATE] service visit, the technician “inspected and treated all 4 nurses’ stations, kitchen area and dishwasher room, rehab gym and nourishment rooms for occasional invaders”. On the [DATE] service visit, the technician “inspected and treated kitchen area and dishwasher room, all 4 nurses’ stations, and rehab gym for occasional invaders; inspected and treated the country inn for prior mice activity; replenished RTUs (mouse bait stations) as needed”. On the [DATE] service visit, the technician “inspected and treated all 4 nurses’ stations and dining room for occasional invaders; inspected and treated the country inn office for prior mice activity”. On the [DATE] service visit, the technician “checked logbooks; mice activity reported in room [ROOM NUMBER]; inspected and treated kitchen area and dishwasher room, and all 4 nurses’ stations for occasional invaders; inspected and treated room [ROOM NUMBER] for mice activity”. On [DATE] at 6:35 AM the survey team observed additional mouse droppings in the conference room behind boxes of copy paper. The Licensed Nursing Home Administrator (LNHA) and the Regional Clinical Nurse were notified of the mouse droppings and acknowledged the surveyors. In an interview with the Licensed Nursing Home Administrator (LNHA) at 7:10 AM on [DATE], the surveyor conveyed to the LNHA that there was a complaint submitted to the Office of Healthcare Quality (OHCQ) from a Resident’s family regarding a rodent in the facility. Additionally, the surveyor conveyed that the All State Pest Management Service company found occasional invaders, mice, and evidence of mice activity during their weekly visits in various locations of the facility, including Resident rooms. This concern with pests and rodents was indicated on the pest management service inspection reports that were reviewed by the surveyor from the company’s service visits on [DATE] through [DATE]. The LNHA acknowledged the surveyor’s concerns regarding pests and rodents in the facility. At the time of the survey exit no additional information was provided by the facility related to maintaining an effective pest control program.