STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215226	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehab at Autumn Lake Healthcare	515 Brightfield Road Lutherville, MD 21093

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews it was determined that the facility failed to ensure 1) a resident's comprehensive care plan included a resident's medical need regarding oxygen and medication, 2) to develop and implement a comprehensive, person-centered care plan to address a resident's significant change in condition related to hospice admission and end-of-life care needs, and 3) to conduct quarterly care plan meetings. This was evident for 1 (Resident #5) out of 2 residents reviewed for respiratory care, 1 (Resident #5) of 5 residents reviewed for medications,1 resident (Resident #77) out of 1 resident reviewed for hospice care, and 1 (Resident #90) out of 5 complaints reviewed during annual survey. The findings include: 1a) A care plan is a resident-centered document that outlines identified needs, goals and interventions to guide the care provided. It must directly reflect the residents minimum data set (MDS), as the MDS identifies the resident's conditions, risks, and functional status. Any problems, risks, or changes identified on the MDS should be addressed in the care plan with appropriate goals and interventions, and the care plan should be updated to remain consistent with the resident's current assessed needs. On 12/04/2025 at 1:05 PM, an observation of Resident #5 revealed that the resident was on oxygen. On 12/05/2025 at 11:15 AM, review of section O of the MDS dated [DATE] revealed that Resident #5 was receiving oxygen at the facility. Further record review failed to reveal that oxygen was included in Resident #5's comprehensive care plan. On 12/05/2025 at 1:21 PM, an interview with the Director of Nursing (DON) revealed that the expectation was that oxygen would be in the care plan based on the medical services provided to meet the resident's needs. On 12/08/2025 at 9:33 AM, the concerns were reviewed with the DON and she indicated that she understood. 1b) On 12/08/2025 at 9:41 AM, review of Resident #5's medical record revealed that he/she was admitted to the facility on [DATE]. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the same time, further record review revealed that the resident was admitted on [DATE] with an active diagnosis of mood disorder (a mental health condition where moods can change quickly), and was ordered risperidone (a medication used to treat mood disorder) upon admission. On 12/08/2025 at 9:52 AM, further record review failed to reveal that the condition nor medication that the resident was actively receiving treatment for was addressed in the comprehensive care plan. On 12/08/2025 at 11:29 AM, an interview with the Director of Nursing (DON) revealed that the expectation was that resident diagnoses that were actively being treated at the facility should be included in the comprehensive care plan. The surveyor reviewed the concern with the DON and she indicated she understood. 2) The MDS (Minimum Data Set) is a federally mandated, standardized assessment tool used in Skilled Nursing Facilities (SNFs) to comprehensively assess a resident's clinical and functional status. The MDS is used to develop individualized care plans, monitor quality of care, and determine Medicare reimbursement. Care Area Assessments (CAAs) are a crucial part of the Minimum Data Set (MDS) process in skilled nursing facilities, serving as prompts for detailed reviews of specific resident issues like delirium, nutrition, falls, or mood, forming the basis for personalized care plans by an interdisciplinary team (IDT) to address needs, set goals, and enhance resident well-being. These assessments trigger deeper evaluations beyond basic MDS data, ensuring comprehensive, individualized care plans for residents. On 12/05/2025 at 9:08 AM, review of physician orders dated 10/15/2025 showed an order for a hospice consultation for Resident #77, and physician orders dated 10/16/2025 showed the resident was admitted under [NAME] Hospice services, effective 10/15/2025. On 12/05/2025 at 9:26 AM, a review of the resident's most current comprehensive and most recent quarterly Minimum Data Set (MDS) and Care Area Assessments (CAAs) related to the resident's significant change in condition on 10/15/2025 was conducted for areas pertinent to the resident's end-of-life care, services, and needs. On 12/05/2025 at 9:31 AM, review of pertinent documentation revealed that the resident began receiving hospice services effective 10/15/2025; however, no care plan addressing hospice or end-of-life care needs was present in the medical record. On 12/05/2025 at 9:37 AM, review of the resident's care plan showed that the care plan was not initiated until 12/04/2025, the date the survey team arrived at the facility. On 12/05/2025 at 10:01 AM, an interview was conducted with the Unit Manager, Licensed Practical Nurse (LPN) #4, when asked about expectations regarding care plans, he stated that a baseline care plan was completed upon admission and reviewed and updated as needed. When asked about care plan updates following a change in condition, he stated that care plans were updated after a change in condition. When asked when the resident was admitted to hospice, he stated that the resident was admitted in October and added that the care plan should have been initiated on the day of hospice admission or the following day. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/2025 at 10:36 AM, an interview was conducted with the Director of Nursing (DON). When asked about expectations for care plan initiation, the DON stated that a resident should have a baseline care plan within 24 hours of admission and a comprehensive care plan completed within 14 days. The DON further stated that care plans should be initiated or updated following a change in condition, particularly when the change was significant. When asked when the care plan for this resident was completed, the DON stated that it was completed on 12/04/2024. When asked when the care plan should have been initiated, the DON stated that the care plan should have been initiated following the resident's change in condition on 10/15/2025, and not on 12/04/2025. On 12/05/2025 at 10:43 AM, when the DON was informed that the failure to initiate and update the care plan following the resident's significant change in condition was a concern, she acknowledged the concern and stated that audits would be conducted, and education would be provided to nursing staff regarding timely care plan initiation and updates. 3) On 12/09/2025 at 1:39 PM, a review of complaint intake #2624519 revealed concerns related to Resident #90s hearing and vision, which had been reported to facility staff on multiple occasions. A review of Resident #90s medical records revealed the resident was admitted to the facility on [DATE], for skilled rehabilitation services. Further review revealed that an initial interdisciplinary care conference was conducted on 04/16/2025, with the resident, two family members, Social Services Director, and Director of Physical Therapy were in attendance. Further review of the medical records revealed that the resident was discharged from physical and occupational therapy services on 06/30/2025 and remained in the facility under long term care services until September 2025. Records review failed to show evidence of a care plan meeting nor conference following 04/16/2025. On 12/10/2025 at 1:45 PM, the surveyor requested care plan meeting notes and attendance records after 04/16/2025 from the Director of Nursing (DON). At 2:10 PM, the Social Services Director informed the surveyor that she was unable to provide the requested information, as no additional care plan meetings were conducted following 04/16/2025.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of records, review of complaints and staff interviews, it was determined that the facility failed to 1) ensure narcotic record books were consistently signed by both incoming and outgoing nurses, 2) ensure that drug records were maintained in a manner that accounted for all controlled drugs and allowed for reconciliation of dispensed and administered medication, and 3) ensure that medication was administered in accordance with physician ordered parameters. This was evident for 8 of 8 medication carts observed during the medication storage task, 2 (Complaint #2646715, #2613978) of 5 complaints reviewed, and 1 (Resident #71) of 2 residents reviewed for pharmacy services during the annual survey. The findings include: The MDS (Minimum Data Set) is a federally mandated, standardized assessment tool used in Skilled Nursing Facilities (SNFs) to comprehensively assess a resident's clinical and functional status. The MDS is used to develop individualized care plans, monitor quality of care, and determine Medicare reimbursement. Brief Interview for Mental Status (BIMS) is a quick cognitive screening tool used in healthcare (especially long-term care) to check for memory, orientation, and recall (like remembering three words) in patients, scoring 0-15 to flag potential impairment. 1) On 12/09/2025 at 8:50 AM, during a medication cart observation on unit 2, the surveyor reviewed the narcotic record book and observed multiple missing signatures. During an interview with Registered Nurse (RN) #15 who confirmed the missing signatures, when asked whether narcotics were counted at shift change that morning, RN #15 stated, Yes. When asked about expectations for signing the narcotic record book, she stated that the book should be signed by the incoming nurse and the outgoing nurse. On 12/09/2025 at 9:28 AM, during a medication administration observation of Licensed Practical Nurse (LPN) #17 on unit 3, the surveyor reviewed the narcotic record book and observed that it had not been signed that morning by the incoming nurse. LPN #17 confirmed that she was the incoming nurse and stated that the lack of signature was an oversight. The surveyor also observed multiple missing signatures in the narcotic record book. When asked about expectations regarding signing the narcotic record book, LPN #17 stated that the outgoing nurse and incoming nurse were expected to sign the narcotic record book every shift after counting the controlled medications together. On 12/09/2025 at 9:49 AM, during an observation of medication cart on unit 4, the surveyor reviewed the narcotic record book and observed that it had not been signed that morning. LPN #13 stated that it had been a busy morning and that she had counted the narcotics with the outgoing nurse but forgot to sign the record. The surveyor also observed multiple missing signatures in the narcotic record book. When asked about expectations for signing the narcotic record book, LPN #13 stated that both the outgoing nurse and incoming nurse were required to sign the narcotic record book across all shifts after completing the count together. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/2025 at 11:32 AM, during an interview with the Director of Nursing (DON), the surveyor asked about expectations regarding signing narcotic record sheets. The DON stated that incoming and outgoing nurses were expected to count and account for all narcotics at shift change and that both nurses were required to sign the narcotic record sheet. The surveyor discussed the concerns identified during medication observations with the DON, who stated that she would provide education for all staff involved. 2) On 12/10/2025 at 12:47 PM, review of Complaint #2646715 revealed that on 10/17/2025, a complaint was filed with the State Agency alleging that on 10/04/2025 and/or 10/05/2025, the facility's narcotic record sheet reflected that a controlled substance had been administered to the complainant's loved one; however, the resident reported that he had not received the medication. The complainant further stated that review of the resident's chart did not show documentation that the medication was administered during that period. On 12/10/2025 at 12:52 PM, review of Resident #91's clinical record revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 on the Minimum Data Set (MDS) assessment dated [DATE], indicating that the resident was cognitively intact at the time of the alleged incident. On 12/11/2025 at 7:15 AM, review of Resident #91's physician orders in the electronic health record revealed an active order dated 09/29/2025 for Oxycodone HCl 5 mg oral tablet, to be administered 5 mg by mouth every six (6) hours as needed for pain rated 5–10. On 12/11/2025 at 7:28 AM, review of the controlled drug administration record provided by the pharmacy revealed that Oxycodone HCl 5 mg was removed from the narcotic supply on the following dates and times: 10/04/2025 (no time documented) 10/05/2025 at 8:15 AM 10/05/2025 at 1:56 PM 10/05/2025 at 9:00 PM 10/12/2025 at 9:50 AM On 12/11/2025 at 7:39 AM, review of the resident's Medication Administration Record (MAR) for October 2025 failed to show documentation that Oxycodone HCl 5 mg was administered to the resident on the above-listed dates, despite the medication being removed from the controlled drug supply. (continued on next page)

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	215226	A. Building B. Wing	12/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/2025 at 9:49 AM, during an interview with the Director of Nursing (DON), the surveyor asked about expectations regarding the administration and documentation of controlled substances. The DON stated that the nurse administering a controlled medication was expected to sign the pharmacy-provided controlled drug record to indicate removal of the medication from the narcotic supply and document the remaining count and then sign the MAR to indicate that the medication was administered to the resident. When informed of the discrepancy between the controlled drug removal record and the lack of documentation on the MAR, the DON stated that such practice was not acceptable. The DON further stated that all licensed nursing staff would be educated on proper documentation of controlled substances and that random audits would be conducted to prevent recurrence. 3a) On 12/10/2025 at 8:50 AM, review of Complaint #2613978 revealed that on 09/10/2025, a complaint was filed with the State Agency alleging that Resident #87 reported experiencing increased pain due to missed pain medication on multiple occasions, which reportedly interfered with the resident's ability to participate in therapy services. On 12/10/2025 at 8:57 AM, review of Resident #87's clinical record revealed a MDS discharge assessment dated [DATE], which documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the resident was cognitively intact at the time of the complaint. On 12/10/2025 at 9:34 AM, review of Resident #87's physician orders revealed an order dated 08/18/2025 for Oxycodone HCl 5 mg oral tablet as follows: Give three (3) tablets by mouth every four (4) hours as needed for pain rated 7 to 10, and Give two (2) tablets by mouth every four (4) hours as needed for pain rated 4 to 6. On 12/10/2025 at 9:59 AM, review of the Medication Administration Record (MAR) revealed that Oxycodone HCl 5 mg, two (2) tablets, prescribed for pain rated 4 to 6, was administered on the following dates and times when the documented pain level did not meet the ordered parameters: 08/28/2025 at 5:07 AM with pain level of 0 08/29/2025 at 7:33 PM with pain level of 0 08/30/2025 at 5:50 AM with pain level of 0 09/04/2025 at 7:31 PM with pain level of 8 09/05/2025 at 6:36 AM with pain level of 10 09/09/2025 at 6:02 AM with pain level of 8 09/12/2025 at 10:22 AM with pain level of 0 09/15/2025 at 5:35 PM with pain level of 7 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the MAR revealed that Oxycodone HCl 5 mg, three (3) tablets, prescribed for pain rated 7 to 10, were administered on the following dates and times when the documented pain level did not meet the ordered parameters: 08/28/2025 at 00:04 AM with pain level of 0 08/31/2025 at 6:34 AM with pain level of 0 08/31/2025 at 10:00 PM with pain level of 5 09/05/2025 at 11:45 AM with pain level of 5 04/06/2025 at 8:16 PM with pain level of 6 09/09/2025 at 1:31 PM with pain level of 6 09/10/2025 at 6:00 PM with pain level of 5 09/11/2025 at 8:34 PM with pain level of 6 09/12/2025 at 00:37 AM with pain level of 6 09/18/2025 at 6:33 PM with pain level of 0 09/19/2025 at 6:49 AM with pain level of 5 On 12/10/2025 at 12:16 PM, during an interview with the Director of Nursing (DON), the surveyor asked about expectations regarding administration of pain medications. The DON stated that pain medications were to be administered strictly in accordance with physician orders and the prescribed pain scale parameters. When informed of the findings related to both under-medication and over-medication of Resident #87, as well as administration of pain medication when not clinically indicated, the DON acknowledged the concern and stated that the staff involved would be reeducated. The DON further stated that all nursing staff on the unit would receive reeducation regarding adherence to physician orders and proper pain assessment and medication administration. 3b) On 12/09/2025 at 12:57 PM, a review of Resident #71's Medication Administration Record (MAR) for November and December 2025 revealed that the following medications were administered outside of the physician ordered parameters: Doxazosin Mesylate 4mg was ordered to be held for systolic blood pressure (SBP) less than 110mmHg, however, the medication was administered on the following dates: 11/08/25 SBP of 104/73 11/11/25 SBP of 99/58. 12/08/25 SBP of 101/56 (continued on next page)

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	215226	A. Building B. Wing	12/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Losartan Potassium-Hydrochlorothiazide 100-25mg was ordered to be held for SBP less than 110mmHg, however, the medication was administered on the following dates: 11/09/25 SBP of 104/57 11/11/25 SBP of 99/58. Nifedipine 60mg was ordered to be held for SBP less than 110mmHg, however, the medication was administered on the following dates: 11/10/25 SBP of 102/60 11/20/25 SBP of 83/56 12/05/25 SBP of 106/59 Carvedilol 25mg, was ordered to be held for SBP less than 110mmHg, however, the medication was administered on the following dates: 11/10/25 SBP of 102/60 11/14/25 SBP of 92/57 12/05/25 SBP of 106/59 Clonidine 0.1mg, was ordered to be held for SBP less than 110mmHg, however, the medication was administered on the following dates: 11/05/25 SBP of 106/72 11/09/25 SBP of 104/57 11/10/25 SBP of 102/60 11/20/25 SBP of 97/48 12/05/25 SBP of 106/59 Oxycodone 5mg was ordered on 10/27/25, for staff to administer three tablets as needed (PRN) for severe pain rated 7-10 and was discontinued on 11/07/25. The medication was administered on the following dates: 11/03/25 pain score of 5- medication administered. 11/04/25 pain score of 6-medication administered. 11/05/25 pain score of 5-medication administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/06/25 pain score of 5-medication administered 11/07/25 at 12:33 AM, pains score of 5-medication administered. 11/07/25 at 06:31 AM, pain score of 5-medication administered. Oxycodone 5mg was ordered on 11/07/25, for staff to administer three tablets PRN for severe pain rated 7-10 and was discontinued on 11/19/25. The medication was administered on the following dates: 11/10/25 pain score of 4-medication administered. 11/14/25 pain score of 4-medication administered. 11/17/25 pain score of 1-medication administered. Oxycodone 5mg was ordered on 11/19/25 for staff to administer three tablets PRN for severe pain of 8-10 and was discontinued on 11/28/2025. The medication was administered on the following dates: 11/22/25 at 6:30 PM, pain score of 0-medication administered. 11/22/25 at 9:30 PM, pain score of 0-medication administered. 11/23/25 pain score of 0-medication administered. 11/24/25 pain score of 2-medication administered. 11/27/25 pain score of5-medication administered. Oxycodone 5mg was ordered on 11/28/2025 for staff to administer two tablets PRN for pain rated 5-10. The medication was administered on the following dates: 12/04/25 at 3:03 AM, pain score of 1-medication administered. 12/04/25 at 6:08 AM, pain score of 0-medication administered. 12/04/25 at 1:11 PM, pain score of 3-medication administered. 12/06/25 pain score of 0-medication administered. The November 2025 MAR included an order to offer non-pharmacological interventions including repositioning, food or drink, and back rubs prior to administering PRN medication and to document interventions. A review of records from 11/01/2025-11/30/2025 showed these services were not documented as offered prior to medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/2025 at 1:26 PM, during an interview, the Director of Nursing (DON) explained that staff are expected to administer medications as ordered by the physician's parameters and document when medications are held if the order parameters are not met. The surveyor review Resident #71's MAR for November and December 2025 with the DON which showed medications were administered outside of the physician's parameters. The DON acknowledged the findings and stated staff education would be provided.