

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/06/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Long Green		STREET ADDRESS, CITY, STATE, ZIP CODE 115 East Melrose Avenue Baltimore, MD 21212	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interviews with residents and staff, and a review of facility processes, the facility failed to ensure an adequate supply of clean, well-maintained linen was available to meet the needs of residents. This deficient practice affected 4 (Resident #5, #10, #15, #16) of the 16 residents reviewed during the complaint survey. The findings include: On 10/1/2025 at 10:15am, the surveyor reviewed two complaints from residents #5 and #10 regarding the facility's failure to supply well-maintained linen to its residents. On 10/2/2025 at 12:30pm, interview with resident #15 revealed a complaint of a lack of well-maintained linen being available to the residents of the facility. On 10/3/2025 at 1:20pm, interview with resident #16 revealed a complaint of the facility's failure to supply enough linen to the residents. Resident #16 alleged that the linen that was supplied to the residents was in ill-repair. On 10/6/2025 at 8:00am - 8:15am, the complaint survey team made several observations of linen carts on all units that failed to have enough linen to supply the residents on the unit. The linen that was on the carts was discolored and threadbare. On 10/6/25 at 8:20am, the survey team observed Laundry Tech #9 folding clean linen onto a linen cart. The survey team observed that the linen cart was less than half filled with clean linen. The clean linen that was observed on the cart contained many pieces of linen that were discolored and threadbare. Interview with Laundry Tech #9 revealed that the observed linen cart was all of the remaining clean linen available to the facility's residents. Laundry Tech #9 confirmed that the facility did not have enough linen for the facility's residents and the laundry techs work with what they have. Laundry Tech #9 also commented on the lack of available linens when he/she stated, I have worked in this facility since it was a [name of previous management company] and this the worse I have seen. On 10/6/25 at 8:40am, the survey team interviewed EVS Supervisor #6 regarding the lack of an adequate supply of well-maintained linen for the facility's residents. EVS Supervisor #6 confirmed that the facility does not have enough well-maintained linen for its residents. The survey team asked EVS Supervisor #6 about the process of maintaining an adequate linen supply for the facility's residents. EVS Supervisor #6 stated that he/she is given \$676 monthly from Healthcare Services Group to replace any damaged or unserviceable linen. The facility is supposed to supply any additional funds as necessary to ensure the facility has adequate linen supplies. EVS Supervisor #6 admitted that he/she failed to receive any additional funds from the facility in the year that he/she has been employed in the facility as the EVS Supervisor. The last time EVS Supervisor #6 requested funds from the facility's administration for the linen supply was in late July or early August of 2025. The survey team asked EVS Supervisor #6 if he/she consulted with their supervisor about the lack of adequate linen supply for the facility's residents. EVS Supervisor #6 confirmed that he/she consulted their supervisor about the problem and was advised to follow the instructions given by the facility's administration. On 10/6/25 at 11:00am, during an interview with the Administrator and District Manager # 7, the survey team expressed concerns of the lack of an adequate, well-maintained linen supply for facility residents. The survey team also stated that resident complaints and observations confirmed the lack of an adequate linen supply. District Manager #7 admitted that the facility did not have enough well-maintained linen for the residents. After surveyor intervention, District Manager # 7 stated he/she would take steps to ensure that all residents in the facility would have a supply of personal linens when needed. The steps included searching for linen in the resident's rooms, obtaining emergency linens from partner nursing homes, and purchasing linen as necessary.</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>Based on medical record review and interview with staff it was determined the facility failed to notify a resident/resident representative in writing of a room change, including the reason for the change. This was evident for 1 (Resident #1) of 6 residents reviewed for a facility reported incident during the complaint survey. The findings include: On 10/3/25 at 10:00 AM, a review of Resident #1's EMR (electronic medical record) revealed documentation that Resident #1 resided on the Main Street Unit, in same room, in A bed, since 4/11/25. On 10/3/25 at 12:30 PM, an observation of the room where, per the medical record Resident #1 resided found the resident's name posted outside of the room, indicating Resident #1 resided in A bed, in the room. At that time, Resident #1 was not observed to be in the room. On 10/6/25 at 10:35 AM, an observation of Resident #1's room revealed the A bed mattress was bare and without linens, Resident #1 was not in the room at that time. As the surveyor was leaving the room, Resident #16, who resided in B bed in the room, asked the surveyor if s/he was looking for him/her. When made aware the surveyor was looking for the resident who resided in A bed, Resident #16 reported that Resident #1, had resided in A bed, however the resident had changed rooms and now resided in the room next door, in the B bed. An observation of the room next door, where Resident #16 reported Resident #1 now resided revealed Resident #1 in the room, sitting in a wheelchair next to the B bed, and the resident was being attended by Staff #3, Geriatric Nursing Assistant (GNA). At that time, Staff #3 confirmed Resident #1 resided in that room, in B bed. Following the observation of Resident #1 residing in a room not documented in the medical record, a further review of Resident #1's EMR failed to reveal documentation to indicate that prior to the room change, the resident and/or the resident representative had received written notice of the room change which included the reason for the room change, or that the room change had been requested by the resident. On 10/6/25 at 11:10 AM, during an interview, Staff #4, Licensed Practical Nurse (LPN), stated Resident #1 likely changed rooms on 10/3/25 because when the nurse worked on 10/2/25, Resident #1 resided in the room that was documented in the EMR, and when Staff #4 worked on 10/4/25, s/he found out that Resident #1 had changed rooms, and no longer resided in the room that was documented in the EMR. On 10/6/25 at 11:44 AM, the Nursing Home Administrator (NHA) was made aware that Resident #1 had been moved to a different room, and there was no documentation of the room change or evidence that the resident/representative had received written notice, including the reason for the change prior to the resident's room change, found in the medical record. The NHA indicated s/he was unaware Resident #1 had changed rooms. At that time, the surveyor, along with the NHA, returned to the nursing unit, where Resident #1 was observed in a room that was different than the room documented in the EMR and, during a brief interview, Staff #3, GNA confirmed Resident #1 currently resided in the room which was different than the room documented in the EMR. The NHA acknowledged the above concerns at that time.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation, interviews with residents and staff, and a review of facility processes, the facility failed to ensure an adequate supply of clean, well-maintained linen was available to meet the needs of residents. This deficient practice affected 4 (Resident #5, #10, #15, #16) of the 16 residents reviewed during the complaint survey. The findings include: On 10/1/2025 at 10:15am, the surveyor reviewed two complaints from residents #5 and #10 regarding the facility's failure to supply well-maintained linen to its residents. On 10/2/2025 at 12:30pm, interview with resident #15 revealed a complaint of a lack of well-maintained linen being available to the residents of the facility. On 10/3/2025 at 1:20pm, interview with resident #16 revealed a complaint of the facility's failure to supply enough linen to the residents. Resident #16 alleged that the linen that was supplied to the residents was in ill-repair. On 10/6/2025 at 8:00am - 8:15am, the complaint survey team made several observations of linen carts on all units that failed to have enough linen to supply the residents on the unit. The linen that was on the carts was discolored and threadbare. On 10/6/25 at 8:20am, the survey team observed Laundry Tech #9 folding clean linen onto a linen cart. The survey team observed that the linen cart was less than half filled with clean linen. The clean linen that was observed on the cart contained many pieces of linen that were discolored and threadbare. Interview with Laundry Tech #9 revealed that the observed linen cart was all of the remaining clean linen available to the facility's residents. Laundry Tech #9 confirmed that the facility did not have enough linen for the facility's residents and the laundry techs work with what they have. Laundry Tech #9 also commented on the lack of available linens when he/she stated, I have worked in this facility since it was a [name of previous management company] and this the worse I have seen. On 10/6/25 at 8:40am, the survey team interviewed EVS Supervisor #6 regarding the lack of an adequate supply of well-maintained linen for the facility's residents. EVS Supervisor #6 confirmed that the facility does not have enough well-maintained linen for its residents. The survey team asked EVS Supervisor #6 about the process of maintaining an adequate linen supply for the facility's residents. EVS Supervisor #6 stated that he/she is given \$676 monthly from Healthcare Services Group to replace any damaged or unserviceable linen. The facility is supposed to supply any additional funds as necessary to ensure the facility has adequate linen supplies. EVS Supervisor #6 admitted that he/she failed to receive any additional funds from the facility in the year that he/she has been employed in the facility as the EVS Supervisor. The last time EVS Supervisor #6 requested funds from the facility's administration for the linen supply was in late July or early August of 2025. The survey team asked EVS Supervisor #6 if he/she consulted with their supervisor about the lack of adequate linen supply for the facility's residents. EVS Supervisor #6 confirmed that he/she consulted their supervisor about the problem and was advised to follow the instructions given by the facility's administration. On 10/6/25 at 11:00am, during an interview with the Administrator and District Manager # 7, the survey team expressed concerns of the lack of an adequate, well-maintained linen supply for facility residents. The survey team also stated that resident complaints and observations confirmed the lack of an adequate linen supply. District Manager #7 admitted that the facility did not have enough well-maintained linen for the residents. After surveyor intervention, District Manager # 7 stated he/she would take steps to ensure that all residents in the facility would have a supply of personal linens when needed. The steps included searching for linen in the resident's rooms, obtaining emergency linens from partner nursing homes, and purchasing linen as necessary.</p>		