STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215031	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Long Green	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)
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 medical record review and staff interviews it was determined that the facility failed to developed and implement a person centered care plan. This was evident for 2 Resident's, Resident #12 and Resident #103 reviewed during the annual recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. On 2/3/2026 at 10:30 AM, medical records were reviewed and revealed that a care plan for Diabetes Mellitus was not developed or implemented for Resident #12. On 02/03/2026 at 11:01 AM, the Director of Nursing, DON, was interviewed and asked who was responsible for implementing and updating the care plan for each resident. The DON stated that the admitting nurse did the baseline care plan, which included skin, falls, pain, medications, and diet. The Unit Managers, UM, would then update the care plan based on the Minimum Data Set, MDS, the resident's diagnosis, and any change of condition. On 02/03/2026 at 11:34 AM, the DON was interviewed and asked if Resident #12 had a diagnosis of Diabetes Mellitus and, if so, if they could provide documentation of Diabetes Mellitus on Resident #12's care plan. On 02/03/2026 at 11:36 AM, Resident #12's records were reviewed and revealed on the Diagnosis Report for Resident #12 had an onset date of 10/5/2017 for Type 2 Diabetes Mellitus. The Medication Administration Record, MAR, had an order to check Resident #12's blood sugar three times a week. On 02/03/2026 at 12:30 PM, the DON stated that a copy of Resident #12's care plan could not be provided for Diabetes Mellitus because it was not completed. The DON verbalized that not having a care plan developed and updated based on the resident's diagnosis and change in condition was an issue. On 01/28/26 at 7:02 AM a review of Resident #103 electronic health record (EHR) revealed the resident was admitted to the facility on [DATE] status post (S/P) surgical repair L femur on 10/30/25. The surgical site had Steri-strips with bruises per provider note. Further review of the EHR revealed a person-centered care plan was not initiated to care for the surgical site. On 01/28/26 at10:45 AM during an interview with the Director of Nursing it was verbalized Resident #103 was admitted with the surgical site; and should have had a care plan initiated. The resident was seen by the wound team for the surgical site.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215031	A. Building B. Wing	02/03/2026

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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 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. Number of residents sampled: Number of residents cited: Based on review of residents' medical records and interview with facility staff, it was determined that the facility failed to ensure that a physician's order for daily pedal pulses and weekly abdominal girth measurements to be recorded and reviewed by the provider. This is evident in 1 of 1 residents (resident #25) reviewed in the annual certification.The findings include:During an initial interview of resident #25 it was noted that they had severe edema in both of their feet and ankles . When reviewing the medical record it it was noted that the resident's provider had ordered that the resident have pedal pulses taken every shift and that it be documented either positive or negative. That order was written on 11/13/2025. The resident also had an order for the weekly measurement of their abdominal girth dated 9/24/2025. Though in the Task Administration Record) TAR, it was documented that these tasks were completed, no data of the measurements was recorded in the TAR, the resident's chart or any other line of communication to the provider. The DON was asked about this and after their investigation stated that the provider failed to initiate the supplemental data command in PCC (the electronic medical record) and consequently the nursing staff did not have a place to document the measurements. Employee #19 was interviewed and asked if the unit had a separate place to record this data and they said no. The DON was unable to account for why in the 2 months for the pedal pulses or the 4 months for the abdominal girth measurement that neither the nursing staff or the provider had done anything to correct the issue and provide the means for measurements to be recorded.