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	05/15/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview it was determined that the facility staff failed to notify a resident's representative when the resident was transferred to the hospital. This was evident for 1 (Resident #7) of 6 residents reviewed for Quality of Care.The findings include: During review of complaint #2960075 Resident #7's medical record was reviewed on 5/14/26 at 8:36 AM. The record revealed that Resident #7 was capable of making his/her own medical decisions, had a family member listed as their Emergency Contact #1 and a friend listed as Emergency Contact #2. An Infection note dated 5/4/26 by Staff #1 a Licensed Practical Nurse (LPN), the facility's Infection Preventionist indicated During assessment resident was noted to be lethargic and difficult to arouse. Resident responded to tactile stimulation. Provider notified. New orders were given to transfer resident out to an acute care facility for further evaluation. A Change in Condition progress note dated 5/4/26 indicated that Resident #7 was transferred to the hospital due to a change in mental status. Section M. Resident Representative Notification indicated that Resident #7 was the Resident Representative who was notified of the hospital transfer. The medical record did not reflect that one of Resident #7's designated Emergency Contacts was notified when the resident had a change in mental status, was difficult to arouse and was transferred to the hospital for evaluation on 5/4/26. During an interview on 5/14/26 at 2:55 PM the Director of Nursing was made aware of the above findings. She was unable to find documentation that either of Resident #7's emergency contacts were notified.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interview, it was determined the facility staff failed to ensure resolution of all grievances by failing to ensure that written grievance decisions included the steps taken to investigate a grievance. This was evident for 1 (#7) of 3 residents reviewed for neglect. The findings include:Review of a complaint #2960075 on 5/14/26 at 8:36 AM revealed concerns which included but were not limited to Resident #7 not receiving proper wound care on a daily or timely basis and being left in bed for extended periods of time. The facility's Grievance logs from 1/2026 to 5/7/26 were requested and reviewed on 5/7/26 at 10:53 AM. There were no grievances pertaining to Resident #7 in the binder. On 5/14/26 at 11:35 AM the surveyor requested any grievances filed by or on Resident #7's behalf. At 1:45 PM on 5/14/26 the Administrator provided a Grievance Form dated 4/23/26 5:38 PM. The Grievance reflected concerns that Resident #7's wound care was missed at times and was not completed that morning; and staff were not assisting the resident to get out of bed daily despite the Residents request. The Administrators signature was in the designated spaces for the Investigator, Grievance Official and Administrator.The results section stated: Wound care was completed for the date of 4/23/26. [Resident #7] gets out of bed daily. The corrective action section stated: Unit manager & supervisors are ensuring that [Resident #7] gets out of bed daily. [Resident #7's] wound care being completed & followed by the wound provider & in house wound team. The Grievance Form did not include the steps taken to investigate the grievance, including pertinent findings. There was no documentation to indicate that a written decision was issued to the person who submitted the grievance. In an interview on 5/14/26 at 1:50 PM the Administrator indicated the Grievance form for Resident #7 was not in the Grievance binder because it was on his desk. When asked what he did to investigate the concerns, he indicated that he spoke to staff, and they told him that Resident #7 got out of bed every day. When asked how and when he issued a written decision to the person who submitted the grievance, he indicated he called and left a message for them to call back but they never did. Resident #7's Treatment Administration Record Audit Reports for April 15-30, 2026, were reviewed on 5/15/26 at 11:56 AM. Resident #7's wound treatments scheduled to be completed on day shift (7AM - 3PM) were signed off at 8:39 AM on 4/23/26. However, Resident #7's wound treatments were not signed off as completed until after 3:30 PM on 7 out of 16 days during that timeframe. The Kardex is the form used by the GNA's to document the care and services they provide to the residents. Review of Resident #7's April 2026 Kardex on 5/14/26 at 8:36 AM revealed that s/he was not assisted out of bed on 6 out of 17 days from 4/14/26 - 4/30/26. A review of the facility's Resident and Family Grievances policy and procedure revealed it was implemented 12/23/22, last reviewed by the facility on 11/3/25 and included the regulatory requirements. These concerns were reviewed with the Administrator and Director of Nursing on 5/15/26 at approximately 12:00 PM.Cross reference F 684.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview it was determined the facility staff failed to follow Nursing Standards of Practice by failing to ensure wound care treatments were completed timely, signed off at the time of completion and signed off by the person who performed the treatment. This was evident for 1 (#7) of 6 residents reviewed for Quality of Care. The findings include:During review of Complaint #2960075, Audit Reports of Resident #7's Treatment Administration Record (TAR) for April 15-30, 2026, were reviewed on 5/15/26 at 11:56 AM. The audits included a timestamp documenting the time each treatment was signed as completed by the nurse administering it.The review revealed: Resident #7's wound treatments were scheduled to be completed every day shift (7AM - 3PM). On 4/24/26 new physician orders changed several of Resident #7's wound treatments to every day shift and every evening shift (3PM - 11PM). On 7 out of 16 days from April 15 - 30, the day shift dressing changes were not completed until after 3:30 PM. On 4/25/26 the residents wound treatments scheduled for day shift were signed off at 5:11 PM his/her evening shift wound treatments were signed off at 4:54 PM, 17 minutes prior to the day shift treatments. On 4/26/26 the day and evening wound treatments were signed off as completed within 2 hours 15 minutes of one another. The Administrator was present during the review and was shown the documentation. He stated, you don't know that they just didn't sign them off at that time. When asked what he meant, he suggested that the treatments may have been completed earlier but signed off at the times reflected in the TAR Audit. He was asked if that was the case, how would anyone know when the treatments were actually done. He replied, I guess you really don't. He was made aware that the standards of practice for nursing include that medications and treatments are to be signed off at the time of administration. An interview was conducted with the Director of Nursing (DON) on 5/15/26 at 12:20 PM, the Administrator was also present. The above concerns were reviewed. The DON indicated that the wound nurse performs the day shift wound care/treatments Monday - Friday, that he (the wound nurse) is probably doing the wound care/treatments during the day and the nurse assigned to the resident signed off that they were done. She agreed that the Nursing Practice Standards include that medications and treatments are to be signed off by the person administering the medication or treatment and at the time it was done.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined the facility staff failed to maintain complete and accurate medical records by failing to ensure 1) a resident's record included the actions taken to pursue a court appointed guardian, and 2) a resident's record accurately reflected their skin status upon readmission. This was evident for 2 (#5 and #2) of 6 residents reviewed for Quality of Care.The findings include:1) An Advance Directive is a legal document that allows a person to specify their medical care preferences and appoint a trusted person to make healthcare decisions for them if they become unable to communicate or make decisions themselves. Resident #5's medical record was reviewed on 5/8/26 at 12:36 PM during review of Complaint #2966326. The record revealed that the Resident did not have an Advance Directive. The resident was certified by 2 physicians as lacking capacity to make medical decisions on his/her own behalf on 4/8/26. No documentation was found in the record to indicate the resident had relatives to act as his/her surrogate decision maker or had a court appointed guardian. In an interview on 5/8/26 at 1:40 PM the Director of Nursing (DON) revealed the resident's cognitive capacity had gradually declined. Social Services and Admissions were unable to contact the only family member listed in the residents' contacts. She indicated that the Social Worker and Administrator were in the process of seeking a court appointed guardian for Resident #5 and the Medical Director was also involved. When asked where to find documentation regarding the process she indicated she knew there were emails but wasn't sure if anyone documented it in the resident's medical record. On 5/8/26 at 1:56 PM the Administrator indicated that he was in touch with the facility's legal team regarding Resident #5's guardianship, they started seeking guardianship on 4/15/26 and have been attempting but were unable to reach the resident's family member. He reported - we're in the process of trying to get places of past residences and assets. He was asked where to find documentation in the resident's record that reflected the facility's efforts and process for seeking a guardian. He stated, It's not in there. 2) A pressure ulcer is damage to the skin and underlying soft tissue caused by prolonged or intense pressure which limits blood flow to the tissue leading to tissue damage or death. Initial damage can start within 1 to 2 hours of sustained pressure, particularly in high-risk individuals. During review of Complaint #2999544 Resident #2's medical record was reviewed on 5/11/26 at 11:00 AM. The record revealed the resident had multiple pressure ulcer wounds including but not limited to both thighs, upper buttock/sacrum, right hip, left heel, and right lateral foot. The resident was hospitalized from [DATE] - 5/9/26. A Case Management Discharge Report from the hospital included multiple pressure wounds present on admission. The wounds on the resident's right foot included an unstageable pressure injury on the heel with no open areas or drainage noted. readmission physician orders dated 5/9/26 included orders for wound care of multiple sites. An admission nursing progress note dated 5/9/26 14:12 (2:12 PM) did not mention pressure ulcers but indicated On arrival, assessment completed.The Nursing Admit/Readmit Screener (admission Nursing Assessment) dated 5/9/26 21:33 (9:33 PM) was present in Resident #2's record and revealed:Section C.10. Skin Integrity, included blank diagrams of the human body, spaces and a key to identify location, type, size and stage of any skin injuries present at the time of the assessment. Section C.10 of Resident #2's assessment was blank. There was no documentation identifying the number, type, stage, size or condition of the Residents wounds at the time of his/her readmission to the facility. Review of the resident's record on 5/12/26 at 10:00 AM revealed Wound Assessment reports by Staff #2 the wound care Nurse Practitioner (NP) who documented that Resident #2 had 7 wounds which were documented as acquired before 5/9/26 and 1 unstageable wound on Resident #2's right heel with 5/9/26 as the date the wound was acquired. During an interview on 5/12/26 at 1:17 PM the Director of Nursing (DON) was made aware that there was no assessment of the presence and condition of the resident's wounds upon readmission to the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She indicated that the resident returned to the facility on a Saturday just before the change of shift, the resident had orders for wound treatments upon readmission, which were completed as ordered, and the Wound NP assessed Resident #2's wounds on Monday during her rounds. She confirmed that she was unable to find an assessment of the resident's wound status upon his/her readmission to the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews and record review it was determined the facility staff failed to implement standard infection control practices during wound care. This was evident for 1 (#2) of 6 residents reviewed for Quality of Care.The findings include:Complaint #2999544 and Resident #2's record were reviewed on 5/11/26 at 9:15 AM. The record revealed the presence of a pressure wound on the resident's right heel that was not assessed upon readmission to the facility on 5/9/26.In an interview on 5/11/26 at 11:51 AM Licensed Practical Nurse (LPN) Staff #3, confirmed he was the facility's wound nurse. He indicated his role was to round with the Wound team and complete wound documentation. He indicated he and the wound Nurse Practitioner (NP) Staff #2 were preparing to see Resident #2. He obtained permission from the resident, for the surveyor to observe his/her wound care.Resident #2's wound care was observed on 5/11/26 at 12:55 PM. LPN #3, NP #2, Staff #4 a Unit Manager (UM) and the Surveyor donned protective gowns, masks and gloves prior to entering the resident's room.Upon entering the resident's room, Resident #2 was observed lying in his/her bed. LPN #3 advised the resident that they were there to change his/her wound dressings and the resident agreed. LPN #3 placed the dressing change supplies including wound cleanser, gauze, ointments and xeroform (Petrolatum) gauze, directly on the residents overbed table which contained multiple personal items belonging to the resident. He did not establish a clean field on which to place the clean items. LPN #3 removed the old dressing from the resident's right lateral foot and cleansed the wound. NP #2 measured the wound by placing a paper measuring tape across the wound in each direction, wrote the measurements down and took photos of the wound with a cell phone, laying the phone and the measuring tape on the resident's bottom bedsheet when finished. The prescribed treatment was obtained from the resident's overbed table and applied to the wound by LPN #3. The dressing was secured by wrapping the resident's foot with gauze and a sock was applied by NP #2 and LPN #3.This process of removing the old dressing, cleansing the wound and applying a new dressing was repeated with all of Resident #2's wounds moving from the wounds on the resident's right foot, to left heel, they removed the suprapubic catheter dressing, changed the right upper thigh dressing then applied a clean dressing to the suprapubic catheter site. The resident was assisted to roll onto his/her left side, and dressings were changed for the wounds on his/her sacrum, right and left buttocks. The resident was assisted onto his/her right side, and the dressing was changed to a large deep wound on the resident's posterior left thigh. UM #4 labeled the clean dressing with the date and time for each of these wounds. They removed their gloves, masks and gowns and sanitized their hands just prior to exiting the resident's room. NP #2 carried the cell phone out of the room touching it with her bare hand. During the process, LPN #3 and NP #2 failed to set up and utilize a clean field for the clean dressing and treatment supplies or place a clean barrier under the wounds. They wore the same pair of gloves from the time they entered the room until they exited, failing to change gloves and sanitize their hands between handling soiled and clean dressing supplies. NP #2 laid the cell phone and measuring tape onto the resident's bed sheet between each use, handling them, then touching the other wounds with the same measuring tape and gloves. Additionally, upon entering the room, the surveyor observed that Resident #2's urinary catheter collection bag was lying on the resident's groin/lap area and was approximately 1/3 full of urine. The bag remained in this area until he/she was assisted to roll from side to side when it was placed on the mattress beside the resident. After the dressing changes were completed, LPN #3 picked up the bag, struggled to manipulate the hook then hung the bag on the bed frame. While doing so, he held the bag above the resident's groin and turned it over several times causing urine to flow back into the tubing. Review of the facility policy for Clean Dressing Change on 5/12/26 at 10:08 AM revealed it included setting up a clean area with needed supplies, placing a barrier cloth or pad under the wound. It also included washing hands and donning clean gloves: prior to placing the barrier, after removing the existing dressing, after cleansing and measuring the wound prior to application of creams/ointments and clean dressing; and discarding (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves and washing hands afterward. An interview was conducted with Staff #1 the Infection Preventionist (IP) on 5/12/26 at 12:30 PM. She was asked how she monitors the practice of staff related to infection prevention. She indicated that she would make frequent rounds, watch for any concerns, provide on the spot education and monitor the need for in-service education for a larger group or all staff. She was asked if she observes wound care. She indicated that the wound nurse took care of wounds throughout the week and that she did not typically go with him. She indicated that she would check behind staff to see if the treatments have been done based on the dated and initialed dressings. She was made aware of the concerns related to Resident #2's dressing changes and handling of his/her catheter bag on 5/11/26. In an interview on 5/12/26 at 1:17 PM the Director of Nursing (DON) was made aware of the above concerns. She indicated that IP#1 informed her and the Regional DON a few minutes prior.