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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on lack of documentation and interviews it was determined that the facility staff failed to complete a yearly performance review of Geriatric Nursing Assistants. This deficient practice was discovered during the recertification survey.The findings include:On 02/02/26 at 2:09 pm the surveyor reviewed GNA#34 & GNA#35 employee records. GNA #34 was hired on 07/03/24. There was no documentation to verify the GNA received an annual evaluation since they were hired. GNA #35 was hired on 05/29/08. There was no documentation to verify the GNA received an evaluation within the past year.On 02/02/2026 at 3:52 pm during an interview with the Director of Nursing (DON) the surveyor asked does the nursing staff receive yearly evaluations? The DON verbalized after orientation they have the unit manager ask them how they are doing. If they need assistance their concerns are addressed by Human Resources Director #22 or the Administrator. A daily check-in is done with the GNA's and nurses. Every Friday they discuss a topic that needs to be addressed with the nursing staff. Technically they are supposed to meet with Assistant Director of Nursing #2 every 6 month to re-evaluate where they are from when they first started. The surveyor asked was there documentation to verify that an evaluation was done. The DON verbalized, no.On 02/03 26 at 12:37 PM a review of GNA # 39 and GNA #41 employee records; neither of the GNA's had an annual evaluation for the surveyor to review. GNA #39 was hired on 05/05/21. GNA #41 was hired on 08/01/01.

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with facility staff, it was determined that the facility failed to maintain food service equipment in a manner that ensures sanitary food service operations to prevent possible foodborne illness. This was evident during the initial, and follow-up tours of the kitchen. The findings include: Cross-contamination refers to the transference of harmful substances or pathogenic microorganisms to food via hands, food contact surfaces, sponges, cloth towels, or utensils that have not been properly cleaned after contacting raw food and then touching ready-to-eat foods. Cross-contamination can also arise from inadequate dishwashing procedures that fail to effectively wash, rinse, sanitize, and air-dry all food equipment in the kitchen area. On 01/21/2026 at 7:40 AM, the surveyor conducted an initial kitchen inspection with Staff #6 after calibrating stem thermometers in a container of ice water, and the following non-compliance were identified: Unclean Equipment in the Food Preparation and Storage Areas: NOTE: 2 of 3 Cadco mobile food carts were in use for transporting hot foods to residents in designated food distribution areas for each unit.3 of 3 Cadco mobile food carts were in a state of disrepair, thus preventing the maintenance of smooth, cleanable service areas necessary to prevent the accumulation of dust, debris, food particles, and bacterial proliferation:a. Heating element dial knob faceplates were chipped and/or broken.b. The sneeze guard was broken/cracked and secured with pieces of general-purpose masking tape.c. The metal strip on the sides and the plastic corner edges of the equipment were lifted, chipped, cracked, and/or torn.d. Excessive accumulation of dust, dirt, and spilled food was observed both inside and outside the units. Food plates, cups, and utensils were stored atop the unclean and unsanitized surfaces of these mobile food carts.e. All wheels on the equipment were heavily soiled, with significant accumulation of hair wrapped around the axles. 2. Two exposed air handlers and associated exposed ductwork were located in the center of the kitchen food preparation and ware washing areas:a. The air handler with exposed ductwork in the middle of the kitchen was discharging condensation/gray water onto the kitchen floor. A cloth drape (e.g., bed sheet/blanket) had been placed on the floor next to the floor sink to prevent the spillage of gray water onto the kitchen floor.b. The contractor tapes on both air handlers and the exposed ductwork were lifted and peeling from the units.c. Excessive accumulations of dust, debris, and/or dirt were present on the exposed ductwork.d. The vent covers from these exposed ductworks showed excessive accumulations of dust, debris, and/or dirt, which was being dispersed directly onto the food preparation areas and beneath the clean dishrack. The clean dishrack was observed to be soiled with excessive dust and debris accumulation. 3. The wall adjacent to the air handler had a large hole (approximately 8 inches by 24 inches) exposing a waterline. 4. The electrical outlet cover on the floor in the center of the kitchen was lifted and rusted. 5. The electrical panel board for the food preparation line was lifted and rusted exposing wires. 6. The storage room next to the walk-in coolers was cluttered, poorly lit, and missing a light bulb. 7. The deli slicer was unclean. All kitchen equipment must be washed, rinsed, and sanitized every four hours after use. 8. The microwave was propped up on a sheet pan. The underside of the microwave was rusted. 9. Bulk food storage containers were unlabeled/not stored in a designated area. 10. The hand sink on the cookline was obstructed by a lidded 55-gallon trash can. 11. All cooking equipment beneath the canopy hood were unclean. 12. The convection oven was not positioned directly underneath the canopy hood. 13. The floor tiles beneath the convection ovens were cracked. 14. The canopy hood was missing a light bulb. 15. The canopy hood metal baffle filters were unclean. 16. The interior and exterior of the ice machine were unclean. 17. The ice scoop was stored in an unsanitary condition. 18. The coffee drip pan, drain line, and floor sink were unclean. 19. Walls, floors underneath the equipment, and ceilings throughout the kitchen were unclean. 20. Multiple cracked or chipped floor tiles and cove bases were observed throughout the kitchen. 21. The rear (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	entrance door jamb was in a state of disrepair. 22. Wall and ceiling penetrations were observed near the food storage room (at the electrical panels).Walk - in Refrigerator 23. Compression fan covers were unclean. 24. Food items, including cups of applesauce, mashed potatoes, and pudding, were stored unlabeled. 25. Shelving units were unclean. 26. Door gaskets were unclean.Walk - in Freezer 27. Compressor fan covers were unclean. 28. The compressor evaporator cover was torn. 29. Ice buildup from the compressor was observed on top of opened food boxes. 30. Ice buildup was present underneath the shelving unit. A bag of ice on the floor, positioned on the bottom of a shelving unit, could not be removed. 31. Door gaskets were unclean and torn.Ware Washing Area: 32. The Champion rack conveyor dish machine was unclean. Excessive dust, dirt, food particles, lime, and calcium buildup were observed on the interior and exterior of the unit. 33. The dish machine curtains at both ends of the unit were warped and/or torn. 34. The wall between the dish machine prewash side was covered in rust and a mold-like substance, which had resulted in a large hole (approximately 4 inches by 7 inches). 35. The dish machine vent stacks with adjustable dampers were detached/improperly connected to the ceiling ventilation system. 36. The edges of the wall panels were unsealed, causing the wall panels to [NAME]. 37. The perimeters around the floor sinks were rusted and unclean. 38. The floor sink strainers were undersized with excessive buildup of food debris. 39. The stopper for the sanitizing water vat of the 3-compartment sink was broken. 40. Plate dome covers were observed in a condition of wet nesting. 41. Food and food contact equipment were stored less than 10 inches off the floor. The bottom shelves should be elevated at least 18 inches off the floor to prevent splashing from mop water.Nonfunctional Equipment Throughout the Kitchen Area: 42. Stem thermometer for measuring internal food temperatures. 43. Fountain soda dispenser on a rolling cart. 44. Floor Mixer situated between the walk-in coolers. 45. Two-door reach-in refrigerator located adjacent to the walk-in freezer. 46. One of two convection ovens positioned beneath the canopy hood. 47. One of three Cadco mobile food carts situated beneath the canopy hood. 48. Hand sink paper towel dispenser by the cookline. 49. Dishwasher booster heater. 50. Hot water supply needed at the ware washing area hand sink.At 9:30 AM, both the Maintenance Director and the Administrator were notified of the deficient practices listed above. The Maintenance Director confirmed that the nonfunctional equipment would be removed, repaired, and/or replaced from the kitchen. On 01/28/2026 at 11:30 AM, the surveyor conducted a follow-up inspection regarding the functionality of the dish machine, and the following concerns were identified: 51. The dish machine final rinse gauge was nonfunctional. 52. The dish machine drain line near the clean side of the conveyor line was leaking gray water onto the kitchen floor. 53. The clean side of the dish machine was spraying water directly onto the kitchen floor. 54. The dish machine final rinse temperatures did not achieve 120 degrees Fahrenheit. 55. The dish machine automatically shut off even with continuous loading of racks onto the conveyor line. Staff #6 was required to manually turn on the unit. 56. A bottle of chemical was stored on top of the clean dish side. 57. A wet rag was stored inside the hand sink. 58. The ware washing room entrance door was in a state of disrepair. On 01/29/2026 at 2:00 PM, the surveyor informed the Administrator and the Maintenance Director about the non-commercial ice cooler, which had a chipped, cracked, soiled and broken lid that was located in the first-floor Nourishment room. They both inspected the unit and confirmed that the ice cooler would be replaced with a commercial unit capable of draining melted ice, and being properly washed, rinsed, sanitized, and air-dried to prevent potential cross-contamination of ready-to-eat food, such as ice.On 02/03/2026 at 11:10 AM, during the surveyor's interview with the Ecolab technician to verify the functionality of the dish machine, it was noted that the hand sink exhibited slow cold-water pressure. Staff #6 confirmed that the Maintenance Director had been notified of the cold-water pressure issue at the hand sink and it will be repaired immediately.

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, it was determined that the facility failed to maintain essential equipment in proper operating conditions. This was evident for 10 of the 10 pieces of equipment reviewed during the annual survey.The findings include:All essential kitchen equipment, including but not limited to walk-in coolers, steam tables, dishwashers, convection ovens, stoves, and warming cabinets, must be maintained in safe operating condition in accordance with the manufacturer's specifications and remain accessible throughout kitchen operations.Laundry equipment (e.g., washing machines, dryers) must be used and maintained according to the manufacturer's instructions for use to prevent microbial contamination of the system. On 01/21/2026 at 7:30 AM, an initial tour of the kitchen was conducted with Staff #6. The following kitchen equipment was observed to be nonfunctional and/or not maintained in safe operating condition:A nonfunctional two-door reach-in refrigerator was located adjacent to the walk-in freezer.2 of 2 steam thermometers were non-calibrated, failing to register around 32 degrees Fahrenheit (F) in a cup of ice water.The top-level convection oven did not reach proper baking/cooking temperatures.1 of 3 Cadco mobile food carts located underneath the canopy hood was nonfunctional.An air handler with exposed ductwork in the middle of the kitchen was draining condensation/grey water onto the kitchen floor. A cloth drape (e.g., bed sheet/blanket) was placed in front of the unit floor next to the floor sink to prevent grey water spillage onto the kitchen floor.The dishwasher was in disrepair.The dishwasher booster heater was nonfunctional.At 8:45 AM, the Maintenance Director was notified of the nonfunctional kitchen equipment listed above. The Maintenance Director acknowledged that the kitchen equipment would be replaced or repaired as soon as possible. On 01/28/2026 at 11:40 AM, Staff #6 confirmed that the high-temperature dishwasher had been switched to a low-temperature chemical dishwasher, which must reach 120 degrees F in accordance with the manufacturer's specifications. Both the surveyor and Staff #6 verified the functionality of the mechanical dishwasher by placing a DishTemp thermometer and a stem thermometer through the dishwasher multiple times to measure the highest final rinse temperatures, which read 110 degrees F and 98 degrees F, respectively.In addition, the surveyor pointed out that the final rinse temperature gauge on the dishwasher unit registered zero degrees F. Staff #5 and Staff #6 confirmed that the final rinse temperature gauge was nonfunctional. On 01/29/2026 at 1:40 PM, Staff #4 obtained food temperatures from the Cadco mobile food cart in the [NAME] unit dining/activities room following the lunch service. The temperature of the remaining chicken pieces in the food bin measured 106 degrees F, which verified the residents' complaints regarding the serving of cold foods. The surveyor observed that the surface of the Cadco mobile food cart was cold to the touch. Both Staff #4 and Staff #5 confirmed the unit was cold to the touch, suggesting it may not have been connected to a power source during the lunch service. The dietary staff acknowledged that 2 out of 3 Cadco mobile food carts will be scheduled for repairs. On 01/30/2026 at 3:30 PM, the surveyor observed Staff #16 sorting clean and dirty linens from the laundry machine that had been previously washed. The surveyor observed several washcloths and a pillowcase that still had stains on them while Staff #16 was sorting and asked why the linens were coming out of the machine soiled. Staff #10 and #16 replied that the laundry aides were trained to rewash the soiled laundry from the middle unit. The surveyor asked Staff #16 to open the washing machine on the right side of the middle unit to visually inspect the washed linens and found that steam/vapors escaped into the 51 degrees F ambient room temperature. The surveyor asked whether the middle unit produced steam/vapors after the wash cycle completion and opening the unit door, and the staff replied, no. At 3:40 PM, Staff #10 was notified that 2 out of 3 laundry machines were not in working condition. The washing machine on the left side of the middle unit had been out of order for several years and had an Out of Order signage posted on the unit. The middle unit was not effectively cleaning linens; consequently, employees were (continued on next page)

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	trained to sort and rewash the dirty linens. Therefore, only 1 out of 3 laundry machines was in proper operating conditions to provide clean linens for over 100 residents in the facility.Furthermore, the surveyor noted that 1 of 3 dryers was not in use while clean, washed, wet linens were sitting in the rolling cart. The surveyor asked why the washed linens were not being placed in the dryer unit. Staff #16 stated that the unit near the wall was not reaching the required temperatures to properly dry the linens.On 02/02/2026 at 3:45 PM, the Administrator provided a copy of the laundry machine service report, which stated that the laundry machines' water temperatures must reach 140 degrees F with the proper dispensing of chemicals (e.g., Chlorine level of 150 parts per million) to prevent microbial contamination of the system.At 4:40 PM, the surveyor documented the completion of the wash cycles for 2 of 3 washing machine units. The following temperatures were measured by inserting a sanitized and calibrated stem thermometer between the washed linens:Middle washing machine: 110.4 degrees F.Washing machine situated on the right side of the middle unit: 121.2 degrees F.The Director of Laundry Services was also present and verified the temperatures recorded above. On 02/03/2026 at 11:45 AM, surveyors conducted a follow-up assessment of the functionality of the washing machine units, again by placing a sanitized and calibrated stem thermometer between the washing machine linens:Middle washing machine: 120.7 degrees F.Washing machine situated on the right side of the middle unit: 132.1 degrees F.The Director of Laundry Services was again present to verify the temperatures documented above. The staff confirmed that a service technician is scheduled to follow up every two months to calibrate both the laundry wash chemical solution pumps and the hot water temperatures. Cross reference to F880

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on the lack of documentation and interviews it was determined that the facility staff failed to ensure Geriatric Nursing Assistants received the required 12 hours of yearly training. This deficient practice was discovered during the recertification survey.The findings include:On 01/28/26 at 11:44 am during an interview with Assistant Director of Nursing (ADON) #2, the surveyor asked how they ensure the Geriatric Nursing Assistants (GNA) receive their yearly 12-hour training. ADON #2 verbalized they have a log and discuss who is coming in for orientation. The log is completed and performed by the staffing coordinator and Human Resources keeps track of their hours. On 08/28/26 at 2:19 pm during an interview with Human Resources Director (HRD) #22 the surveyor asked are they ensuring the GNA's are receiving their 12-hours of yearly training. HRD #22 verbalized the only training they do is with the new hires. They see him/her and Assistant Director of Nursing (ADON) #2. They do on-boarding first and he/she doesn't have anything else to do with their training. They are not sure who is responsible for ensuring they receive their training because that was always done on the clinical side. On 02/02/26 at 2:09 pm the surveyor reviewed GNA#34 & GNA#35 health and training records. GNA #34 was hired on 07/03/24. There was no documentation to verify the GNA received 12 hours of required training in the past year. GNA #35 was hired on 05/29/08. A review of their employee record revealed there was no documentation to verify the GNA received 12 hours of required training in the past year.On 02/03 26 at 12:37 pm the surveyor requested four GNA employee records with their training for review. A review of GNA # 39 employee record revealed their hire date was 05/05/21. Their last documented competencies were completed on 07/23/23. A review of GNA #40 employee record revealed they were hired on 04/01/25. The surveyor was unable to confirm what training the GNA received upon hire. A review of GNA #41 employee record revealed the GNA was hired on 08/01/01. A review of an Resident Abuse Inservice Sheet dated 01/01/26, 01/02/26, and 01/05/26 7-3, 3-11, and 11-7 shifts revealed the GNA received abuse training on 11-7 am shift on one of the recorded dates. There was no documentation of any other training the GNA received.

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on resident council records and interviews it was determined that the facility failed to have resident council meetings regularly as evidenced by the inability to provide resident council meeting minutes during January, February, March, and April 2025. The deficient practice was evident in 4 or 12 months of 2025. This deficient practice was discovered during the recertification survey.The findings include:On 01/30/26 at 11:10 AM during a Resident Council meeting with nine residents, the surveyor asked are resident council meetings held regularly. The residents verbalized they were not having meetings regularly until Activities Director #23 started working at the facility.On 01/30/26 at 1:28 PM during a interview with Activities Director #23 he/she verbalized they started having Resident Council meetings in May. The first meeting Activities Director #23 was held on 05/08/25. Meetings are scheduled to be held on the second Thursday of every month in the first-floor dining room. The surveyor requested to view the binder with the Resident Council meeting minutes and sign-in sheets.On 01/30/26 at 2:29 PM a review of the Resident Council binder there were no meeting minutes on sign-in sheets during the months of January, February, March, or April in 2025.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based upon observation and interview, it was determined that the facility failed to maintain a clean and homelike environment. This was evident for 3 Resident's (Resident #8, Resident #48 and Resident #109) of 3 resident rooms and the first-floor Nourishment Room reviewed during the annual survey. On 01/22/2026 at 1:45 PM, Resident #8 was interviewed and complained of feeling cold. The door to the bathroom was open, and a cold breeze was felt by the surveyor coming from the bathroom. The window was observed to be broken with some clear tape on the broken part of the window, but the tape did not adhere to the broken piece of glass in the windowpane, allowing cold air to enter. On 01/22/2026 at 2:03 PM, the Administrator and Staff #28, the Regional Director of Nursing, were shown the broken windowpane in Resident #8's bathroom. They were asked how this window had been broken. They stated that the bathroom had just been renovated. They acknowledged that the broken window was an issue and stated the maintenance man would cover the broken window until the pane could be replaced. On 01/23/2026 at 10:03 AM, the window in Resident #8's bathroom with the broken windowpane was covered with some black tape. Before the survey was completed, a piece of wood was covering the broken windowpane, which prevented cold air from getting in. The findings include: On 01/21/2026 at 12:35 PM, the surveyor observed water damaged floor panels lifted and buckled off the floor in front of the wall-mounted heating, ventilation, and air conditioning (HVAC) unit in Resident #48's room. On 01/29/2026 at 2:00 PM, the surveyor toured Resident #48's room with the Administrator, who confirmed that the damaged floor panels in front of the HVAC unit would be replaced promptly. On 02/02/2026 at 1:30 PM, the surveyor toured the facility with the Maintenance Director, and the following environmental concerns were identified: Resident #109's Room: Multiple holes were observed on the wall in the area of the residents' headboards. Laminated floor panels behind the toilet were lifted. The toilet flange bolt was excessively rusted and protruding. The sliding closet door had fallen off the track, impeding access to the closet. First-Floor Nourishment Room: Cabinet doors were missing from the cabinets. The cabinet interiors were observed to be unclean and in an unsanitary condition. (continued on next page)

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Multiple cracked floor panels were noted. A non-commercial (residential) refrigerator was unclean and had torn door gaskets. An inoperable commercial refrigerator should be removed to mitigate the potential for pest, insect, and bacterial harborage. The Maintenance Director confirmed that the identified environmental deficiencies listed above will be repaired or replaced promptly.

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the staffing sheets and interview it was determined that the facility staff failed to record the actual hours worked by categories of licensed and unlicensed nursing staff each shift. This deficient practice was discovered during the recertification survey.The findings include:On 01/23/26 at 10:45 am a review of the staffing sheets provided by the facility staff revealed the staffing sheets dated 01/21/26, 01/22/26, and 01/23/26 did not include the total number of licensed & unlicensed nursing staff providing direct nursing care each shift.On 01/23/26 at 12:42 PM during an interview with Staffing Scheduler #26 the surveyor asked if they were aware the posted daily schedule must include the facility name, date, census, and the total number of actual hours worked by licensed and unlicensed staff who provide resident care. Staffing Scheduler #26 verbalized they were not aware; that they just write the HPPD and the supervisor does not update it with the numbers. The surveyor and scheduler went to each unit and reviewed the staffing sheets. The staffing sheets on the units Main, [NAME], [NAME], and Joppa were present but failed to include the number of hours the licensed and unlicensed personnel were scheduled to work each shift. A review of the staffing sheets dated 12/25/25, 01/03/26, 01/17/26, and 01/18/26 revealed the total number of working hours of licensed and unlicensed personnel was not documented every shift.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and medical record review it was determined that the facility failed to ensure appropriate infection control practices during the maintenance of oxygen concentrators. This was evident for 2 out of 2 residents reviewed with oxygen concentrators during the recertification survey.The findings included:During the initial resident screening, it was observed that the humidifier bottle and the oxygen delivery tubing did not have the date it had been installed. This was evident for Residents #67, and #89. With medical record review it was noted that 2 residents had provider orders that instructed staff on the amount of oxygen to be delivered and that the humidifier bottle and oxygen delivery tubing was to be changed weekly and that the date those changes were made were to be labeled on the bottle and tubing.

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 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview with facility staff, it was determined that the facility failed to maintain clean and operational ventilation systems, thereby impairing proper airflow throughout the premises. This was evident in 2 of 2 janitors' closets, 2 of 2 utility closets, 2 of 2 residents toilet and shower rooms, and the mechanical dishwasher ventilation systems reviewed during the annual survey. Local Exhaust Ventilation ([NAME]) systems are designed and engineered to capture and remove contaminants such as excessive heat, steam, condensation, vapor, smoke, odor, and fumes. This is achieved through the calibration of the total pressure, which is calculated as the sum of the static pressure exiting and entering the system, minus the velocity pressure entering the system. In addition, the fan speed, pressure, and power must be adjusted to account for the specific gravity of the contaminant being captured and removed by the [NAME] system, while considering the specific size and air changes of the room. The findings include: On 01/21/2026 at 7:30 AM, an initial tour of the kitchen was conducted with Staff #6, which included verification of [NAME] systems within the kitchen and the janitor's closet that was also used for storing cleaning chemicals. The inspection revealed that the [NAME] system in the kitchen janitor's closet was inoperable.At 8:30 AM, the Maintenance Director was notified of the concerns regarding the janitor's closet next to the kitchen. He confirmed that the noted deficiencies, such as the inoperable exhaust fan, would be repaired or replaced promptly. On 02/02/2026 at 1:27 PM, the surveyor toured the facility with the Maintenance Director to conduct visual observations of the [NAME] systems by placing a thin, paper-like product onto the exhaust fan covers:The Main Street unit soiled utility closet lacked an [NAME] system.The [NAME] unit soiled utility closet's [NAME] system was inoperable.The Jappa unit janitor's closet was in disrepair and not in use; the [NAME] system was inoperable.The second-floor residents' toilet/shower room near room [ROOM NUMBER] was inoperable.In the second-floor residents shared toilet room near room [ROOM NUMBER], the motor was producing a loud grinding noise, and the Maintenance Director stated that it would be repaired or replaced.At 1:49 PM, the Maintenance Director acknowledged that the missing and inoperable [NAME] systems would be installed, repaired, or replaced as soon as possible to ensure adequate air circulation throughout the facility for the residents, visitors, and staff members. On 02/03/2026 at 11:10 AM, the surveyor interviewed the Ecolab technician to confirm the proper operating condition of the mechanical dishwasher. The technician clarified that the mechanical dishwasher unit was not included in the services provided by the Ecolab company. The technician's services were limited to providing chemical supplies and chemical dispensing calibration of the unit. However, both the technician and Staff #6 confirmed that steam and vapors were escaping from both ends of the unit and dispersing throughout the kitchen area. The mechanical dishwasher ventilation system required repair or replacement to effectively capture and exhaust steam and vapors from the kitchen area.

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.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the electronic health record and interview it was determined that the facility staff failed to obtain an order to monitor a resident's blood glucose levels and obtain parameters when the physician should be contacted which is the standard for nursing practice. This deficient practice was evidenced in 1 (#103) of 4 medical records reviewed during the recertification survey. The findings include:On 01/22/26 at 12:31 PM a review of Resident #103's electronic health record (EHR) revealed the resident's glucose was being monitored at least BID (twice a day) since the resident was admitted on [DATE]. A review of the residents' diagnoses revealed the resident had a history of Diabetes Mellitus Type I. Further review of the EHR revealed there was not an order for glucose readings or parameters to notify a physician if the readings were out of a selected range.On 01/22/26 at 12:50 PM during an interview the Director of Nursing the surveyor reported the resident's glucose was being monitored without an order or parameters when the physician should be notified. The DON verbalized an order should have been written with parameters in place when the physician should have been notified. They will review the residents' EHR to verify there was an order and provide the surveyor a copy.On 02/03/26 at 3:00 PM the surveyor did not receive documentation that an order was written with the parameters of when to notify the physician or nurse practitioner.

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 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.

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on employee record review and interviews it was determined that the facility staff failed to ensure a Certified Nursing Assistant (CNA) received their Geriatric Nursing Assistant (GNA) Certification within 4 months of their hire date. This deficient practice was evidenced in 1(#32) of three CNA employee records reviewed during the recertification survey. The findings include:On 01/23/26 at 2:04 PM the surveyor requested that Human Resources Director #22 provide documentation when each CNA received their GNA certification. On 01/23/26 at 2:26 PM during an interview with Human Resource Director (HRD) #22, the surveyor asked when a CNA is hired what amount of time are they allowed to work in Long Term Care (LTC) before receiving their GNA certification. HRD #22 verbalized they believed the timeframe was four months. The surveyor reported that CNA #32's hire date was 06/27/25 and they should have received their GNA certification within four months which would have been 10/27/25. On 01/28/26 at 10:53 AM during an interview with the DON, the surveyor reported that CNA #32's employee record revealed their hire date was 06/27/25 and they should have received their GNA certification within four months. The surveyor asked the Director of Nursing (DON) if GNA #32 was working. The DON reported GNA #32 was on vacation. The surveyor checked the Maryland Board of Nursing website which confirmed that CNA #32 did not have a GNA certification. CNA #32's initial certificate was issued on 05/07/24 and their certificate expires on 01/28/27.On 02/03/25 at 9:12 AM a review of the staffing sheets on Main Street dated 01/21/26 7:00 am - 3:00 pm, 01/21/26 3:00 pm - 11:00 pm, 01/22/26 7:00 am - 3:00 pm, 01/23/26 7:00 am - 3:00 pm, and 01/26/26 7:00 am - 3:00 pm revealed that GNA #32 recently worked during those shifts and continued to work after the surveyor reported they should have their GNA certification. On 02/03/26 at 9:20 AM during an interview with GNA #36 the surveyor asked when they worked with CNA #32? Did CNA #32 receive a different assignment? GNA #36 verbalized that Main Street is LTC. They provide Activities of Daily Living (ADL) care, toileting, assistance with feeding, dressing and they use the Hoyer lift to get the residents out of bed as needed. They all provide the same type of care just different residents.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews it was determined that the facility failed to properly store medication. This was evident in 1 of 3 medication carts reviewed during the annual recertification.The findings include:During the review of medication administration and storage during the annual recertification, it was discovered that a large number (52) of different medication tablets and capsules had fallen into the bottom of the medication cards' drawer. The surveyor removed the tablets and capsules in the presence of employee # 12 who was administering medication at the time and made sure the employee was aware of the problem. The surveyor then spoke with the DON and employee #29 who were made aware of the loose medications found in the cart drawer and the medications were disposed of by the DON

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews with staff, it was determined that the facility staff failed to obtain a diagnostic test and get the results as ordered for Resident (#106) in a timely manner. This was evident for 1 of 21 residents selected for review during the annual survey process. The findings include: On 2/2/2026 at 10:30 AM a review of the medical records showed that Resident #106 was admitted to the facility on [DATE]. The weekly skin evaluation documented that Resident #106's skin the color, temperature, turgor was normal and the integrity of their skin had a healed wound, which was an old scab. On 6/23/2025 an addendum note was reviewed and the note stated that On admission, the area to the sacrum was documented as scabbed area. This is consistent with the hospital discharge summary description of excoriation. As of today, the area was reassessed and was noted to have deteriorated. The scab has been noted to detached naturally. This note is intended to reflect clinical reassessment. Also, on 6/23/2025 a change of condition was completed and documented that the area had reopened to sacrum measuring 8.5cm x 8.5cm.Resident #106 was being seen by a wound practitioner Staff # 37, Nurse Practitioner, NP and on a 7/21/2025 the practitioner documented the Wound has improved again this week. Debridement performed and tolerated well. Wound culture collected. Continue current treatment. Resident # 106 was taking antibiotics pills at the facility. Further review on the medical records on 2/2/2026 revealed that a note was written on 7/24/2025 that Diamond Lab called and informed Staff # 38, Licensed Practical Nurse, LPN at 8:45 AM on 7/22/2025 that the wound culture for Resident #106 were rejected due to being collected in the wrong tube. On 2/2/2026 at 12:30 PM record review revealed that Resident #106 was sent to the hospital on 7/26/2025 by their responsible party for further evaluation of Resident #106's sacral wound. Continued review of Resident # 106 records revealed that they were admitted to the hospital with Systemic Inflammatory Response Syndrome (SIRS) related to infected stage 4 wound and sacral osteomyelitis.On 2/2/2026 at 1:31 PM the Director of Nursing, DON was interviewed and asked what happened to the wound cultures that were ordered for Resident #106 on 7/21/2025. The DON stated they were drawn in the wrong specimen tube, and the lab discarded the sample. The DON was then asked for documentation that the physician/practitioner was notified that the wound culture had been rejected and what they wanted to do. The DON stated she would check.On 2/3/2026 at 9:45 AM medical record review of the infection note revealed that Resident #106 had wound cultures at the hospital which grew pseudomonas, Acinetobacter, and Corynebacterium and was treated in the hospital with IV antibiotics.On 2/3/2026 at 2:05 PM Staff #28, the [NAME] DON and the DON were interviewed. They stated that the lab was called at the time of the incident, and they were told it would take 72 hours to get the correct specimen tube to the facility. Again, the DON and Staff #28, the Regional DON were asked if they could provide a note that the wound cultures were redrawn, and they stated no we cannot. Both the Regional DON and the DON verbalize that this was a concern.

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to ensure that the residents received meals that were palatable, attractive, appetizing, adequately portioned, and served at preferred temperatures. This was evident for 1 (Resident #48) of 1 Resident interview and 2 of 2 dining observations conducted during the recertification survey. The findings include: On 01/21/2026 at 12:35 PM, the surveyor interviewed Resident #48, who expressed ongoing concerns regarding the unappetizing nature of the foods served, specifically noting that they were frequently served cold. At 12:45 PM, lunch was delivered to Resident #48's room. The meal ticket indicated a double portion of Stir-Fried [NAME] with Chicken was served. The Stir-Fried [NAME] with Chicken, which had a watery consistency, contained rice, chopped chicken, chopped celery, and several unidentified ingredients. The resident sampled the food and stated that it was cold and spicy. Therefore, the resident requested a substitution of a double portion of turkey burgers.During the interview with Staff #9, the surveyor requested an explanation of food portions. Staff #9 explained that a regular portion consisted of one ice cream scoop of food, and a double portion would be two ice cream scoops. Staff #9 further explained that Resident #48 had a history of returning meals and requesting substitutions.At 1:15 PM, the surveyor followed up with Resident #48 concerning the double turkey burgers. The resident stated that the substitution was preferable to the main course. On 01/23/2026 at 7:30 AM, the surveyor accompanied the second-floor Cadco mobile food cart and monitored the breakfast service provided to the residents. During this service, a total of 7 returned plates were noted, which include 2 residents who declined breakfast and 5 residents who requested a substitution. At 8:45 AM, the test tray temperatures were recorded as follows:Oatmeal - 168 degrees Fahrenheit (F)Pureed Scrambled Eggs - 155 degrees FPureed Bread - 120 degrees FEgg and Cheese Bake - 110 degrees [NAME] 01/29/2026 at 12:25 PM, the surveyor observed lunch being served to all first-floor residents in the [NAME] dining/activities room. 5 returned plates were observed which include 2 residents who refused lunch, and 3 residents who requested a substitution. In addition, 7 residents ultimately received a substitution because the kitchen had ran out of the main course.On 02/02/2026 at 1:45 PM, the surveyor requested that Staff #6 describe the procedure for requesting meal substitutions to facilitate a smoother transition of residents' preferred food deliveries and prevent potential food shortages. Staff #6 explained that the Geriatric Nursing Assistant (GNA) and/or other staff members could complete the form, which is located on a board near the main dining room door, up to two hours prior to the scheduled mealtime.

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interviews with facility staff, it was determined that the facility failed to ensure the appropriate location and maintenance of the exterior dumpster to prevent the harborage and infestation of pests and insects. The findings include: On 01/21/2026 at 8:40 AM, the surveyor observed the exterior dumpster positioned at the loading dock. Staff #6 and the Maintenance Director were interviewed concerning the placement of the dumpster in this area.At 8:55 AM, the surveyor and the Maintenance Director proceeded outside the rear kitchen entrance door to assess the dumpster area, where they discovered a piece of 4-inch by 12-inch plywood situated next to the rear kitchen entrance door. The Maintenance Director acknowledged that the plywood may have been utilized to prop open the rear kitchen door during food deliveries and/or the removal of trash from the facility.Both the surveyor and the Maintenance Director continued down the loading dock staircase leading to the dumpster area and observed trash and debris scattered around the dumpster location. The Maintenance Director confirmed that the dumpster will be relocated next to the recycle dumpster, further away from the building at the rear parking lot. The loading dock area will be cleaned of scattered trash and debris to mitigate the potential for pests and insects to harbor and infest the facility premises.

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews with facility staff, it was determined that the facility failed to ensure a call bell system was accessible to residents. This was evident for 3 (Resident #1, #44 and #109) of 3 residents' toilet facilities call bell systems reviewed during the annual survey.The findings include:On 01/21/2026 at 1:15 PM, the surveyor observed that the call bell cord was missing in Resident #1's restroom.On 02/02/2025 at 2:00 PM, the surveyor toured the [NAME] unit with the Maintenance Director and observed that the call bell cord was missing in Residents #44 and #109 restrooms.At 2:10 PM, the Maintenance Director acknowledged the missing call bell cords for Residents #1, #44, and #109 would be installed as soon as possible.

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, and interviews with staff and residents, it was determined that the facility failed to maintain a rodent and insect free environment for the residents. This was evident in 2 of 2 resident rooms and the conference room reviewed during the annual survey.The findings include:On 01/21/2026 at 12:45 PM, an interview with Resident #48 indicated that the resident had sighted a rodent within the resident's room.At 12:55 PM, Resident #39 acknowledged that the condition of the resident's room was conducive to pest harborage and confirmed that a rodent had been observed in the room.At 2:00 PM, a review of Resident #39's Care Plan, updated on 9/3/2025, revealed that facility staff had encouraged and educated the resident on the importance of maintaining a clean and clutter-free room.On 01/22/2026 at 9:45 AM, an interview with the Administrator was conducted concerning the facility's intervention process for Resident #39 to clean and declutter the room. The Administrator explained that staff had provided containers to organize belongings, but the resident has consistently declined housekeeping services to enter and remove items from the room.On 01/29/2026 at 9:30 AM, the surveyor observed a rodent running across the conference room and exiting the room through the space at the bottom of the door.On 01/30/2026 at 10:00 AM, a review of pest control service reports indicated that the facility maintained ongoing pest and insect control services for the treatment of rodents, bedbugs, and cockroaches.On 01/30/2026 at 11:00 AM, the Administrator and the Maintenance Director acknowledged the importance of a clean environment for the prevention of pest and insect infestations, and the necessity for vigilance regarding factors that attract insects, such as warehouse boxes, propped-open doors, unsealed wall and ceiling penetrations, and the relocation of the dumpster from the loading dock area, which was situated about 3 feet from the kitchen's rear entrance doors.