STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215074	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Homewood	6000 Bellona 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide the resident or representative with an outcome and/or resolution following the conclusion of a grievance investigation for 1 (R#12) of 6 sampled residents reviewed for grievances.Findings included:A review conducted on 5/14/2026 at 10:02 AM, of a facility policy titled, Resident and Family Grievances, dated 11/3/2025 revealed . Procedure: This facility will not retaliate or discriminate against anyone who files a grievance or participates in the investigation of grievance. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. Take any immediate action needed to prevent further potential violations of any resident rights. Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of resident property immediately to the administrator and follow procedures for those allegations. Forward the grievance form to the Grievance Official as soon as practicable. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance. All staff involved in the grievance investigation or resolution will take steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances.R#12 was admitted to the facility on [DATE] with diagnoses including vascular dementia. The quarterly Minimum Data Set (MDS) dated [DATE] revealed R#12 as moderately cognitively impaired. The resident was independent with toileting hygiene and required set up assistance with lower body dressing.On 5/14/2026 at 10:52 AM a review of the grievance form dated 3/26/2026 revealed a concern about a staff member and R#12s level of care. There were no recommendations, resolutions, or follow-ups identified.An interview with the Ombudsman was conducted on 5/14/2026 at 11:06 AM. The Ombudsman stated they had worked with the facility for over 2 years and issues related to grievance follow-through had been identified.An interview with SW9 was conducted on 5/14/2026 at 11:18 AM. SW9 stated grievance forms were received, copied and forwarded to department heads of the area of concern. SW9 stated investigations and resolutions were usually completed within 3 days. SW9 stated summaries of investigations and resolutions were generally provided in writing. SW9 further stated she was not in the facility during the grievance process for R#12.An interview with the Administrator was conducted on 5/14/2026 at 3:37 PM. The Administrator stated the grievance for R#12 was remembered and grievances were usually directed to SW9, but follow-through regarding the grievance process for R#12 was not completed due to an oversight.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility-reported incident, review of the facility's Abuse Prevention Policy, and review of the facility's investigative documentation, the facility failed to ensure Resident #5 was free from verbal and mental abuse when a staff member yelled at the resident and threatened to have a family member come to the facility to ?take care' of the resident, for 1 of 3 sampled residents reviewed for abuse.Review conducted on 5/14/2026 at 10.15 AM. The Abuse Prevention Policy revealed that the facility policy prohibited verbal and mental abuse toward residents. The policy further indicated residents were to be free from verbal threats, intimidation, harassment, and abusive language by facility staff.Review conducted on 5/14/2026 at 10:23 AM of the facility-reported incident dated 12/24/2025 revealed that Resident #5 reported that the GNA entered the resident's room yelling and threatened to have the GNA's father come to the facility to take care of him. Facility documentation indicated the allegation was immediately reported to nursing administration, and the accused staff member was removed from resident care pending investigation.Review conducted on 5/14/2026 at 10:35 AM of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including quadriplegia, chronic pain syndrome, anxiety disorder, depression, neurogenic bowel, opioid dependence, and generalized weakness.Review conducted on 5/14/2026 at 10:45 AM of the care plan indicated that the resident required extensive assistance with activities of daily living and received interventions related to psychosocial well-being and emotional support.A review conducted on 5/14/2026 11:01 AM of the facility's investigative documentation revealed that the accused GNA acknowledged making statements regarding calling their father to deal with the resident. Witness interviews and staff interviews corroborated that a verbal altercation occurred between the resident and the accused staff member.During observation and interview on 05/12/2026 at 11:13 AM, Resident #5 was observed resting in bed in the resident's room. During the interview, Resident #5 confirmed that the verbal incident involving the GNA occurred.An interview on 5/15/2026 at 11:30 AM with the Director of Nursing (DON) revealed that the allegation was substantiated by the facility based on resident statements, witness interviews, and staff interviews. The DON stated the accused staff member was terminated following completion of the investigation. Review of the facility's investigative documentation further revealed that the allegation was reported to the Board of Nursing, and abuse education was provided to facility staff regarding verbal and mental abuse recognition and reporting requirements.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 ensure staff implemented interventions to prevent a resident from falling from bed during an incontinence change for 1 of 3 sampled residents for accidents. (R#6) The findings include:R#6 was admitted to the facility on [DATE] with diagnoses including unspecified injury at C5 level of cervical spinal cord. The quarterly Minimum Data Set (MDS) dated [DATE] identified R#6 as cognitively intact and dependent on staff for activities of daily living. The care plan dated 4/24/2026 identified a focus related to bed mobility and indicated the resident required the assistance of one staff member to reposition and turn in bed.On 5/11/2026 at 1:56 PM review of a change in condition note dated 2/19/2026 revealed a witnessed fall. Geriatric Nursing Assistant (GNA3) called for assistance. Upon entering the room, the resident was observed sitting on the floor next to her bed. The Resident denied pain or discomfort and vital signs were within normal limits. The resident was assisted back to bed with the help of three staff members. Redness was noted to the skin around the left knee. The Resident's responsible party was notified. The provider was notified. The GNA reported that the resident slid out of bed while care was being provided and was assisted to the floor. On 5/11/2026 at 2:02 PM, review of an x-ray report dated 2/19/2026 revealed no fractures noted. A telephone interview with GNA3 was conducted on 5/11/2026 at 2:13 PM. GNA3 stated they did remember R#6 and was assigned as the resident's GNA that morning. GNA3 stated it was their first day working at the facility and while walking down the hall checking on residents R#6 asked GNA3 to change her/him. GNA3 stated they entered the room and while turning the resident with the pad, the resident's legs slipped off the bed and the resident was guided to the floor. The GNA stated the resident care guide had not been reviewed, they were unaware the resident was paralyzed, and when the resident's legs were turned, the legs slid off the bed. An interview with the Director of Nursing (DON2) was conducted on 5/11/2026 at 12:03 PM. DON2 stated R#6 experienced a fall. DON2 stated the GNA was agency staff and new to the facility. While checking residents, R#6 asked to be changed, and as GNA3 was changing the resident, R#6 was rolled to the side and the resident's legs slipped off the bed. DON2 stated the GNA guided the resident to the floor without serious injury, redness to the left knee was identified, and no complaints of pain were voiced. DON2 stated an x-ray of the left knee was obtained following the fall and no fractures were identified. DON2 stated that aide was not asked to return because the aide was expected to ensure care could be provided safely and the care guide should have been reviewed prior to assisting residents. The resident's care plan was changed to a two person assist after the fall. R#6 no longer resided in the facility. The resident was contacted by email on 5/11/2026 at 12:01 PM and was called 5/12/2026 at 10:34 AM. No response was received.