STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215077	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ruxton	7001 Charles Street Towson, MD 21204

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of an investigation and interview it was determined that the facility staff failed to complete a through investigation of an allegation of abuse. This deficient practice was evidenced in 1 (#1) of 1 resident allegation investigation reviewed during the complaint survey.The findings include:On 05/07/26 at 9:10 am a review of the facility's investigation of the allegation of abuse concerning Resident #1 revealed on 02/26/26 the resident called the police due to an allegation of abuse. Around 1:20 pm the local authorities came to the facility, and the staff became aware of the allegation. On 05/07/26 at 12:44 pm during an interview with Director of Nursing (DON) #2 the surveyor asked who interviewed the staff during the investigation. DON #2 verbalized they and the Assistant Director of Nursing obtained statements from the staff during the investigation. Resident #1 reported a male who had weapons abused them, therefore they interviewed male residents and staff that worked on the unit. They interviewed staff during the time of the alleged incident to find out if they were aware of anything. Director of Nursing #2 confirmed the surveyor was provided the entire investigation. The surveyor requested a copy of the staffing sheet of the unit when the allegation was made. On 05/08/26 at 9:39 am a review of the staffing sheet for the Unit Somerset dated 02/26/26 for shift 7:00 am - 3:00 pm revealed Geriatric Nursing Assistant (GNA) #10 and GNA #11 worked on the unit during the time of the alleged incident; there were no statements to verify they were interviewed. At 9:53 am during an interview with DON #2 the surveyor asked why there were no interviews from GNA #10 and GNA #11 included in the investigation. DON #2 was unable to inform the surveyor why there were no statements from the two GNA's.

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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(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 - Some	Dispose of garbage and refuse properly. Based on observations and interviews it was determined that the facility staff failed to dispose of furniture and refuse in a sealed container. This was evident in 1 of 1 refuse disposal areas observed during the complaint survey.The findings include:On 05/07/26 at 8:33 am the surveyor observed an orange dumpster with the lid and sliding side door opened with a large white garbage bag hanging over the side. The surveyor also observed other items on the ground near the dumpsters:-six plus wooden pallets-a blue mattress-large white garbage bag of waste on the grass-three boxes in front of a brown shed-eight tall wooden cabinetsOn 05/07/26 at 9:07 am the surveyor and Administrator #1 viewed the area around the dumpster. Administrator #1 reported new dumpsters were delivered the previous day and the staff were going to discard the items into the rolling dumpster.On 05/07/26 at 9:10 am during an interview with Maintenance Director #7 the surveyor asked who is responsible for ensuring the dumpsters are being used properly. Maintenance Director #7 verbalized housekeeping, culinary, and central supply staff all use the dumpsters. Maintenance is responsible for keeping the area clean. Sometimes the staff doesn't keep the area clean as they have been instructed to do so. The dumpsters are emptied on Monday, Thursday, and Saturday. They planned to discard the wardrobes in the rolling dumpster.On 05/08/26 at 8:53 am the surveyor observed an orange dumpster was almost full and the top lid was opened and the sliding side door was partially opened. The other items previously mentioned were not removed.

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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 interviews it was determined that the facility staff failed to ensure the clean linen was in a clean area without dust. This was evident in 1 of 1 laundry areas observed during the complaint survey.The findings include:On 05/11/26 at 9:49 am the surveyor observed the air conditioning vent was not covering the vent opening. Further inspection of the clean linen room revealed dust particles on the wall above the table where the clean linen was folded. There were blankets, top sheets, and fitted sheets on the table. Also, the was dark-colored dust particles in the corner near an old vent that was not being used.On 05/11/26 at 9:58 am during an interview with Environmental Services Director #6 the surveyor asked how often the clean linen area was cleaned. EVS Director #6 verbalized the EVS staff are supposed to clean the area daily. They were uncertain when the area was last dusted. They try to make sure the area was cleaned, dusted, and walls wiped regularly.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews it was determined that the facility staff failed to ensure the laundry area maintenance was completed, this was evident in 1 of 1 laundry areas observed during the complaint survey. The findings include:On 05/08/26 at 11:39 am while in the laundry room the surveyor observed water dripping from a hose behind the first washing machine near the entry door. The surveyor asked Laundry Supervisor #8 did the maintenance department know of the leak behind the washing machine. Laundry Supervisor #8 verbalized a repair man was scheduled to make repairs.On 05/11/26 at 9:15 am during an interview with Maintenance Director #7 the surveyor asked to explain their preventative maintenance schedule. Maintenance Director #7 verbalized preventative maintenance is done once a month which entailed changing the filters, checking the power cords, ensuring the doors are latching, ensuring call bells are working, and checking the electrical outlets. They check the connections on the washers and clean the dryers. The surveyor asked how the staff communicates maintenance concerns to the maintenance department. The staff communicates to the maintenance department through word of mouth. They keep track of work orders in TELS, and the staff can use TELS to put maintenance concerns in TELS.On 05/11/26 at 9:23 am while in the laundry room with Maintenance Director # 7 the surveyor observed water dripping on the floor behind the first washing machine. Maintenance Director #7 verbalized the fitting needed to be tightened. Minor Repairs are completed in-house. If there is a maintenance issue the staff will make them aware. The surveyor asked were they made aware of the water dripping behind the washing machine. Maintenance Director #7 responded no. The surveyor walked to the folding room with Maintenance Director #7 where the clean laundry was on the table. The surveyor asked were they aware the vent was not covered. Maintenance Director #7 verbalized they knew the vent was not covered and a new vent covered was ordered. They were waiting for the new vent cover to be delivered. The surveyor asked for documentation to verify the vent cover was ordered. Maintenance Director #7 was unable to verify whether a vent cover was ordered. The surveyor observed a hole in the wall in the folding room. The surveyor asked Maintenance Director #7 were they aware the wall needed to be repaired. Maintenance Director #7 verbalized they were going to make the repair.