STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215081	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Perring Parkway	1801 Wentworth Road Baltimore, MD 21234

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, it was determined that facility staff failed to ensure that a resident was treated with dignity. This was evident for 1 (#5) of 3 residents observed during the complaint survey,The findings include:An observation of Resident #5 on 6/17/26 at 1:23 PM revealed the resident was in a hospital gown. A review of complaint #3034879, regarding Resident #5, on 6/16/26 at 10:40 AM revealed the complainant alleged the resident was not receiving assistance with his/her personal care needs. On 6/17/26 at 1:24 PM the certified nursing assistant (Aid) #22, who was assigned to Resident #5 the day of the observation, was interviewed. She reported that she had given the resident a bed bath, mouth care, and applied lotion on his/her skin. When asked if the resident had family who provided clothes for him/her, Aid #22 reported that the resident had clothes. However, she reported there was no reason she had not assisted the resident to dress in their clothes instead of a hospital gown.The concerns were reviewed with the Director of Nursing (DON) and the Nursing Home Administrator on 6/22/26 at 1:18 PM. They offered no rationale for the deficient practice.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that facility staff failed to maintain the facility in a homelike environment. This was evident for 3 of 3 observations of unit 1 and unit 2. The findings include: 1. On 6/16/26 at 7:05 AM the following observations were made on station 2 nursing unit: Inside room [ROOM NUMBER] there was a trashcan on the left that had a pair of discarded gloves lying beside the trashcan. There were pieces of food scattered in the hallway throughout the unit and beside the facility's sign in the lobby area near the elevator. There was a discarded mask in the hallway sitting on top of a personal protective equipment cart. There was a kitchenette with double doors, that were open and across the hallway was a napkin, straw papers and crumbs scattered in front of resident's room doors. To the right of the kitchen doors was a cart that had dirty dishes piled on it. There were 2 linen carts in the hallway with blue covers. On top of the covers were items such as briefs and an open box of gloves and on the other one were briefs, wipes, trash bags, and large gloves. These items were lying in disarray. 2. On 6/16/26 at 7:09 AM the following observations were made on Station 1 nursing unit: There were gloves found on the floor in room [ROOM NUMBER] and in room [ROOM NUMBER]. The floor in the hallway leading up to room [ROOM NUMBER] was observed to have several blackened areas appearing to look as though something was dripping on the floor. These areas were observed again on 6/17/26 at 8:06 AM and on 6/18/26 at 7:45 AM. On 6/18/26 at 7:44 AM the environmental services District Manager Staff #20 was observed in the hallway using a floor buffer machine on the floor on Station 1 unit. During an interview with Staff #20, he and the surveyor observed the floor outside room [ROOM NUMBER] and it was wet and the stains that were observed on 6/16/26, 6/17/26, and 6/18/26 were gone. He reported that he had placed a more aggressive pad on the buffer machine this morning. The concerns were reviewed with him. He reported that environmental staff were on duty during the day and evening. However, was unable to speak to why the facility was unkempt. The manager of housekeeping had been transferred to another facility. 3. During the initial entrance, at 7:07 AM on 6/16/26 this surveyor observed a pair of gloves on the floor at the entrance to room [ROOM NUMBER] on the 2nd floor. LPN/Supervisor #8 was observed at this time entering the room, stepping over the pair of gloves, then moments later exiting the room, again stepping over the gloves and leaving them on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The tour and observations continued on Unit 1 at 7:18 AM on 6/16/26 a black cart was observed sitting in front of room [ROOM NUMBER] with 2 trays on top of it. The trays contained 2 plates of partially eaten food, dirty dishes, silverware and exposed food. On 6/18/26 at 7:35 AM continued tours of the facility and observations of resident care and interactions with staff. A black cart was observed in front of room [ROOM NUMBER]. There were 2 plates on it with exposed food from the prior dinner meal. Tour again at 8:25 am on 6/18/26 the black cart was still there in front of room [ROOM NUMBER] with the prior days' meal on it. These identified concerns were brought to the attention of the environmental services District manager #20 on 6/18/26 at 7:44 AM as noted above.

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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 that the facility failed to have a process in place to ensure residents/resident representatives had the right to a grievance process. This was evident for 1 (#1) of 6 residents reviewed for complaints. The findings include:On 6/17/26 at 12:00 PM a review of the facility's policy titled, Resident and Family Grievances dated 12/23/22 with the last review on 11/3/25 revealed they failed to enter the name and title of the grievance officer and contact information as indicated on the policy. The policy stated that a resident or family member may voice grievances with respect to care and treatment and other concerns regarding their stay at the facility. In addition, it was noted that a person may use the following forum to voice a grievance verbal complaint to a staff member or grievance official. 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. Then forward the grievance form to the grievance officer as soon as practicable. Upon review of complaint #2791591 for Resident #1 on 6/16/26 at 10:40 AM it was revealed that the complainant reported that they had sent emails to facility staff regarding their concerns and received no response to resolve the concerns. An interview with the complainant on 6/16/26 at 10:41 AM revealed that facility staff failed to inform them of their right to a grievance process when they had a concern. The complainant reported that they continued to have concerns about the resident not receiving the full meal as stated on their meal ticket. An interview with the Director of Nursing (DON) on 6/22/26 at 11:35 AM revealed that when she received a verbal complaint about a resident's care she would not complete a grievance right off the bat When asked if she had received care complaints regarding Resident #1 multiple times over a few months she stated she had, but they were mostly about food. She reported an incident where the resident had not received a sandwich that they were supposed to get extra with their meal. She stated, we had the peanut butter and the bread, so we made [the resident] a sandwich. She further stated that she did not interview the resident or staff to attempt to find out the root cause and determine a solution because it was a food concern. When asked why she had not completed a grievance form when food concerns were continuously being reported to her, she stated that food was not her category and that should be taken care of by the Nursing Home Administrator (NHA). When asked if she had received any emails regarding concerns about Resident #1's care, she reported that she had received 2 emails, however, could not recall what the concerns were. She reported later that she was unable to find the emails to review and discuss with the surveyor. On 6/22/26 at 1:31 PM the concerns were reviewed with the NHA. Although the complainant reported they included the NHA in the emails, she offered no rationale as to why the complainant had not been afforded their right to file a grievance and have a resolution for their concerns.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to have a process in place to ensure that allegations of abuse were reported to the State Agency within the required timeframe. This was evident for 4 of 4 abuse allegations reported to staff for Resident #3. The findings include:1) On 6/16/26 at 10:08 AM a review of the facility's Abuse, Neglect, and Exploitation Policy dated 11/13/23 and last reviewed on 10/17/25 revealed in section VII (7) titled, Reporting/Response that staff were to report all allegations of abuse to the Nursing Home Administrator (NHA) and to the State Agency (SA). A review of the facility's investigation file for the facility reported incident #2982477 on 6/17/26 at 9:23 AM revealed the facility documented that they became aware of the allegation of abuse on 4/13/26 at 3:00 PM when another family member of the resident reported it to the NHA. Further review revealed that Certified Nursing Assistant II (Aid) #10 wrote in her statement that Resident #3 had reported the allegation of abuse to her while she was providing care to the resident. However, according to the email confirmation, facility staff failed to report the allegation of abuse to the SA until 4/13/26 at 5:12 PM. On 6/17/26 at 10:33 AM an interview with Aid #10 revealed that while providing care for Resident #3 after dinner on 4/12/26, the resident reported that she had been beaten by 6 women. She reported that she told the nurse on duty about the allegation of abuse. An interview with the NHA on 6/17/26 at 11:35 AM revealed that she was aware that allegations of abuse were to be reported to the SA within the 2-hour timeframe. She reported she was unaware that the resident had reported the allegation of abuse to Aid #10 on 4/12/26. The concerns were reviewed at this time. 2) A medical record review for Resident #3 revealed a progress note that the resident's representative wanted the resident discharged on 6/2/26. Based on another progress note written by Nurse Practitioner (NP) #24 on 6/2/26 revealed the resident was supposed to discharge on [DATE]. Upon review of complaint #3034284 dated 6/4/26, Resident #3 was taken to the local hospital emergency department (ED) and there was an allegation that the resident was abused at the facility. On 6/16/26 at 1:34 PM a review of the hospital records for the ED visit on 6/2/26 revealed photos of bruising on both sides of Resident #3's neck, a bruise to the right knee, and a bruise on the elbow. The ED physician documented that there was an allegation of abuse and the forensic nurse was notified and the police. He further noted that it was reported the abuse occurred at the facility the resident was residing at and that the complainant brought the resident straight to the ED. An interview with the Director of Social Services on 6/17/26 at 9:40 AM confirmed that the resident was discharged 2 days earlier. She reported she was not present when the resident discharged , but that it was handled by the Director of Nursing (DON).During an interview with the DON on 6/22/26 at 9:28 AM, she reported that the resident representative had some concerns that day and had called 911. When asked specifically what the concerns were she stated she would need to look at her notes.A subsequent interview with the DON on 6/22/26 at 10:00 AM revealed she had not spoken to the daughter or the resident on 6/2/26 but had been approached by the responding police officers. She stated that they told her a family member had concerns about a staff member talking rudely to her [the family member]. They reportedly told her the resident refused to answer their questions. The DON stated she told the police officers that the facility could discharge the resident that day if the family member wanted them to. She stated that the police officer went back and informed the family member who agreed to the discharge. An interview with the NHA on 6/22/26 at 10:50 AM revealed the family member had called her cellphone directly. She was unable to reach the family member when she attempted to call back, so she called the nurses' station. She attempted to ask the family member what was wrong, but she refused to tell her. She reported that the resident's nurse told her the resident was fine, but when the family member arrived, they called the police. She reported that when the police officers talked to the DON, she was on speaker phone and they reported that the concerns (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were not about something that happened that day. On 6/22/26 at 12:18 PM an interview with Certified Nursing Assistant II (Aid) #25 revealed that he was assigned to Resident #3 on 6/2/26. Aid #25 reported that when he arrived to the unit the resident was up in their wheelchair, so he provided care and put the resident back in bed. When the family member arrived and saw him in the resident's room, the family came out in the hallway accusing Aid #25 of abusing the resident and throwing things in the room. When asked if anyone else had witnessed the family member coming out into the hallway, he stated that the nurse assigned to the resident that day. He reported that he told Supervisor #26 about it. Aid #25 explained further that earlier this year the family member was watching him feed the resident and was upset about a comment he made to the resident. This was reported to facility staff and the next time the Aid worked he was asked by Unit Manager (UM) #9 to write a statement about what happened. The Aid #25 further reported that facility staff had not told him that he was not to be assigned the resident in the future and this was the reason the family member was upset. An interview with UM #9 on 6/22/26 at 12:33 PM revealed that she was unable to recall the incident when the family reported Aid #25 and she asked him to write a statement. She stated she recalled another incident where the resident accused someone of pulling his/her arm and she reported that to the DON via email. She reported that she puts everything into an email, so she has a electronic paper trail. She was asked to look review the emails and report back to the surveyors. However, she failed to do so by the conclusion of the survey. On 6/22/26 at 12:46 PM the DON was asked about the 2 incidents, and she reported she was unaware of either of them. She was asked to check to see if they had reported either allegation of abuse to the State Agency (SA). She was made aware that there was an allegation of abuse for Resident #3 on 6/2/26 that facility staff failed to report to her. The concerns that allegations of abuse were not reported to the SA as required were reviewed with the DON and NHA on 6/22/26 at 1:19 PM.Cross Reference: F610

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to have a process in place to ensure that all allegations of abuse were investigated and appropriate interventions put into place to ensure resident were free of abuse. This was evident for 3 of 4 allegations of abuse reported regarding Resident #3.The findings include:A medical record review for Resident #3 revealed a progress note that the resident's representative wanted the resident discharged on 6/2/26. Based on another progress note written by Nurse Practitioner (NP) #24 on 6/2/26 revealed the resident was supposed to discharge on [DATE]. Upon review of complaint #3034284 dated 6/4/26, Resident #3 was taken to the local hospital emergency department (ED) and there was an allegation that the resident was abused at the facility. On 6/16/26 at 1:34 PM a review of the hospital records for the ED visit on 6/2/26 revealed photos of bruising on both sides of Resident #3's neck, a bruise to the right knee, and a bruise on the elbow. The ED physician documented that there was an allegation of abuse and the forensic nurse was notified and the police. He further noted that it was reported the abuse occurred at the facility the resident was residing at and that the complainant brought the resident straight to the ED. An interview with the Director of Nursing (DON) on 6/22/26 at 10:00 AM revealed she was aware that Resident #3's family member called 911 on 6/2/26 because she was at the facility when it happened. She spoke to police who told her the concerns were not recent. She asked the nurse who was assigned to the resident what was wrong but was told everything was ok. However, she reported she did not assess the resident or talk with the family to find out what was wrong. She offered to discharge the resident that day if the family wished to do so.An interview with the NHA on 6/22/26 at 10:50 AM revealed she attempted to talk to the family member over the phone but was unable to find out what was wrong. She reported that she was on speaker phone when the police talked with the DON. On 6/22/26 at 12:18 PM an interview with Certified Nursing Assistant II (Aid) #25 revealed that he was assigned to Resident #3 on 6/2/26. Aid #25 reported the family member went into the hallway and was alleging he abused the resident. He reported that the nurse assigned to the resident and that he told Supervisor #26 what the resident's family member said. However, no one took action to remove the alleged perpetrator from access to the resident and other vulnerable residents or conduct a thorough investigation of the allegation of abuse. During this interview, Aid #25 reported that the same family member previously reported to staff that he made an inappropriate comment while feeding the resident. He stated that he found out when he returned to work at the facility because UM #9 asked him to write a statement about what happened. There was no evidence that this allegation was reported to the SA and a thorough investigation was completed to ensure the residents were free of abuse. While interviewing UM #9 on 6/22/26 at 12:33 PM it was reported that she did not recall the incident reported by Aid #25 with the inappropriate comment but recalled another allegation of abuse. She stated that the resident reported that someone had pulled on his/her arm and that it was hurting. She recalled writing a statement and sending it to the DON. She reported she kept everything in her emails to ensure it was not lost. However, she failed to report back to the surveyor. The facility failed to show that this allegation of abuse was reported, and a thorough investigation competed to ensure the safety of their residents from abuse. On 6/22/26 at 12:46 PM the DON was asked about the 2 incidents, and she reported she was unaware of either of them. She was asked to check to see if they had reported either allegation of abuse to the State Agency (SA). She was made aware that there was an allegation of abuse for Resident #3 on 6/2/26 that facility staff failed to report to her. The DON was asked to check to see if they had any documentation regarding the allegations of abuse and if they were investigated. There was no additional evidence provided at the time of the conclusion of the survey.During an interview with the DON and NHA on 6/22/26 at 1:19 PM they reported they had no knowledge of these incidents. They were informed that if they found additional evidence to the contrary to provide it to the SA. Cross Reference: F609

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review and interview, it was determined that the facility failed to have a process in place to ensure that residents were appropriately discharged from the facility. This was evident for 1 (#3) of 1 discharge reviewed. The findings include:MDS (Minimum Data Set) - is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Care plan - 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. Person-centered care: means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. A paper record review for Resident #3 on 6/16/26 at 1:11 PM revealed 2 provider certifications dated 2/25/26 and 3/3/26 deeming the resident incapable of making decisions due to the diagnosis of dementia. An electronic medical record review for Resident #3 on 6/16/26 at 8:23 AM revealed a history and physical was completed on 2/25/26 that documented the resident had dementia, left side weakness after a stroke, and ambulatory dysfunction. The notes revealed the resident was at the facility for rehabilitation (rehab) services. A review of the care plan for the focus of the resident discharging home when the rehabilitation stay was completed that was initiated on 3/9/26. The goal was that the resident will be discharged when they had reached their rehab/self-care goals. The following interventions were initiated on 3/9/26: assess future placement setting to ensure the resident's needs can be met; complete post-discharge plan, review with resident, and provide a copy; discuss with resident/rep discharge process. The interventions were not resident-centered. There was no evidence on the care plan that staff documented an ongoing discharge planning process that included the IDT (Interdisciplinary Team consisting of nursing, providers, therapy, dietary, and social services). They failed to include the discharge needs of the resident; show there was regular re-evaluations to identify changes in the discharge needs and reflect changes that were made; show that the considered caregiver/support person availability and ability to provide the care/support; show there was input from the resident representative; address the resident's goals of care and treatment preferences; document the resident had been asked about their interest in receiving information regarding returning to the community; and document the referrals for community resources and medical equipment referrals and update the care plan with their responses. A review of the progress notes revealed that on 3/12/26 the Social Services Director Staff #12 wrote that the resident representative was considering long-term care for the resident, however this was not reflected on the discharge care plan. On 4/30/26 Staff #12 wrote a note that she spoke with the resident's representative about completing the Medicaid application timely if the plan was for the resident to stay long-term. On 6/17/26 at 9:40 AM an interview with Staff #12 revealed she had ordered the durable medical equipment for the resident and made a referral to the home health agency. She stated that the resident went home 2 days early, but that the discharge was completed prior to the date she left. She reported she had no concerns with the discharge. During subsequent interview with Staff #12 on 6/22/26 at 10:30 AM she reported that she was not aware of the regulatory requirements for discharging a resident from the facility. She could not recall if she had or had not received training at the time she was hired. The concerns were reviewed with her. On 6/22/26 at 1:19 PM the concerns were reviewed with the Director of Nursing and the Nursing Home Administrator.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review, observation and interviews, it was determined that the facility failed to accurately code a residents' active diagnosis and skin conditions on the minimum data set (MDS). This was determined during the review of complaints related to general care in 2 of 4 residents (#6 and #7). The findings included: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each resident receives the care they need.1. The medical record for Resident #6 was reviewed on 6/17/26 at 1:32 PM. The comprehensive assessment completed on 5/18/26 and the active diagnosis entered in section ?I' stated that the active diagnosis entered in the comprehensive assessment for 5/18/26 documented that Resident #6 had or was treated within the past 7 days with cancer. A comprehensive review of the medical record including the hospital discharge, failed to note any active treatment for cancer, only a ?history of.'The MDS coordinator staff #18 was interviewed on 6/17/26 at 1:32 PM regarding the identified concerns. After her review she followed up to state that a modification will be done that the ?cancer' diagnosis under active diagnosis was entered incorrectly. 2. Resident #7 was observed in bed on 6/16/26 at 7:07 AM and a wound vac (is a dressing system that uses gentle suction to help a wound heal) that was observed sitting on a chair to the left of the resident's bed connected to tubing protruding out from the left side of the bed. Review of the June quarterly MDS on 6/16/26 at 12:10 PM June Quarterly assessment section ?M' skin conditions, failed to code and document the presence of any wounds for Resident #7. MDS coordinator #18 was interviewed on 6/22/26 at 10:05 AM. Of note, everything on section ?M' was dated 5/15/26, however, under #1 for number of unhealed pressure ulcers, the date was 5/29/26. She was asked about the difference in the dates. She stated she recalled this and that she was audited by her corporate office and was told that there was not enough in the medical record to support the coding of the presence of a pressure ulcer. She stated she would follow up to confirm. An email from the facility nursing home administrator on 6/23/26 confirmed this statement which also correlates with the concerns reported to the DON at 10:15 on 6/22/26 that there were no weekly wound records found for Resident #7.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to provide the residents with a quality of care and dignity by timely responding to call bells and providing residents with the appropriate adult incontinence briefs. This was evident during random observations and 1 of 1 resident (#6) observed for the use of incontinence briefs. The findings include: 1. During the entrance and initial general observations conducted on 6/16/26 at 7:00 AM, this surveyor walked past room [ROOM NUMBER], heard and saw the call bell going off. A staff member was seen walking in the opposite direction towards the surveyor. This individual proceeded to go past this surveyor, past the call bell still alarming and proceeded pushed the button for the elevator. This surveyor continued down the hall and the 2nd floor nursing station was visualized to the left with 5 staff all seated around the nurses station. The call bell panel was observed up on the wall and there were 3 call bells that were presently lit up on the panel alarming, including room [ROOM NUMBER] that could still be observed from this observational standpoint.This surveyor introduced self and coworker and the purpose for the visit and requested for a supervisor from any of the 5 individuals sitting at the nursing station. One staff, later identified as the evening supervisor, Staff # 8, notified this surveyor that the Director of Nursing's office was downstairs and this surveyor was welcome to go and get her. During this conversation now 7:17 AM, this surveyor noted that there were still at least 3 call bells going off, with the alarm system to the immediate left of LPN/Supervisor #8's head. This surveyor continued to ask the rest of the staff their names, as staff #8 who was later identified as the night supervisor sat there with the call bells going off.The second staff sitting at the nursing station was then asked her name. She initially refused and stated that she was agency and has nothing to do with any of this. She was then asked if she was still on the clock and cared for any residents last night. She then stated, it doesn't matter, to which this surveyor repeated to her to confirm, her statement. This identified agency certified nursing assistant (Aide) #14, looked away and would not answer any further questions. This surveyor proceeded down the nursing station to each employee asking their names. The call bells continued to alarm, and all the staff continued to sit at the nursing station. This surveyor then proceeded around the remainder of the facility.2. Secondary to allegations of double diapering and neglect of Resident #6 and other residents, on 6/17/26 at 9:38 AM, care for Resident #6 was directly observed. Permission was requested and granted from the resident and certified nursing assistant (Aide) staff #10 notified this surveyor when she was starting.This surveyor noted that Aide #10 brought in and prepped a blue brief for the resident. However, when the resident was undressed, a tan/yellow brief was revealed. This surveyor asked Aide #10 about the discrepancy in the brief's colors. Aide #10 looked at this surveyor and stated that they are supposed to go by the resident size/weights when choosing briefs and that this resident should be in a ?L,' however, last night staff placed him in an ?XL.' The brief was noted bunched up around the sides of the resident and between the legs. Aide #10 further stated that unfortunately sometimes staff do this. On 6/18/26 at 6:45 AM this surveyor approached the 1st floor nursing station after reviewing the assignment board, establishing who cared for Resident #6 the night prior and introduced self. Aide #9 was identified as the staff that cared for Resident #6 the night prior. She was asked if she recalled the color brief that was used on [him/her]. She looked at me and said, I think the tan size, the bigger one, I don't know, they are giving him something for [his/her] bowels so. This surveyor tried to clarify how the staff would determine the appropriate size of adult briefs for a resident. Aide #9 looked at this surveyor and stated, why are you asking me, I don't know what I put on [him/her]. The next Aide sitting at the nursing station, Aide # 6, was also asked how she would determine what size goes to what resident, as there are different colored briefs. She replied to this surveyor What she said.The DON was notified of the observations and interactions with the staff on the night shift at 7:17 AM, she stated well you know that's why some people work on the night shift. A tour of the storerooms, one identified on each (continued on next page)

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	215081	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Perring Parkway	1801 Wentworth Road Baltimore, MD 21234

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit, identified the same items were stocked and available on both floors, the S, M, L, XL briefs were labeled as on the 1st floor but not on the 2nd floor. A look at the individual packages and websites for the current company the facility utilizes revealed that the size of the briefs used for an individual should be based on abdominal circumference not weight. When the identified concerns were reviewed again with the DON on 6/18/26 at 9:37 AM about staff using the wrong size briefs on residents, she stated that they use different brands and colors can change. However, when it comes to briefs and adult diapers it was brought to her attention at this time that the manufacturers go by abdominal circumference, not weights.A review on 6/18/26 at 9:40 AM of Resident #6's medical record failed to reveal any documentation of an abdominal circumference or of a size brief that should be used.Review on 6/22/26 at 11:49 AM of Resident #6's medical record revealed a history of having sacral ulcers and incontinence associated dermatitis (painful skin irritation, caused by chronic exposure to moisture, urine and feces).The overall concern related to the lack of staff response to call bells and placement of inappropriate sized briefs/adult diapers potentially resulting in additional and worsening skin breakdown was reviewed with the facility DON and NHA during exit on 6/22/26.

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F 0689 Level of Harm - 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, observation and interview, it was determined that the facility staff failed to identify and consistently evaluate the contributing factors to a resident fall and ensure appropriate interventions were implemented to prevent future occurrences. This was evident for 1 of 2 (#6) residents reviewed for falls and resulted in harm to Resident #6. The findings include: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. Person-centered care: means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.The medical record for Resident #6 was reviewed on 6/16/26 at 8:21 AM regarding complaint 303105, that Resident #6 had repeated falls without interventions and was hospitalized multiple times.A review of the hospital discharge summary from 5/18/26 prior to this initial admission, documented that it was the 5th hospitalization secondary to falls for this resident prior to coming to the facility with discharge recommendations including 24/7 supervision from the physical therapy and occupational therapy team at the hospital secondary to the residents falls and debilitated condition.An initial admission baseline care plan was established on 5/18/2026 during the admission assessment completed with Resident #6. This noted that Resident #6 had a history of falls, and documented staff orientated the resident to the call bell as the intervention for fall prevention.Continued review of the medical record on 6/16/26 showed that less than 24 hours after initial admission on [DATE], Resident #6 fell on 5/19/26 with superficial injuries on the back and the resident also reported hitting his/her head lightly. On 5/22/26, Resident #6 fell on with no injuries noted, resident attempted to stand independently and was placed back in bed, and on 5/28/26 an assisted fall occurred during a transfer with staff, resident again was placed in bed and given the call light with the bed lowered. During this medical record review, there was no root cause analysis or documented change in the resident plan of care as to the cause of the repeated falls in this short time frame. Then on 5/30/26 resident was found on the floor in the bathroom with injuries noted to the resident back and forehead and a resulting abnormal neurological exam including an abnormal left pupil. Resident #6 developed a subdural hematoma from that unwitnessed fall when the resident attempted to self toilet. On 5/30/26 Resident #6 was sent to the hospital secondary to a fall, the 5th fall since 5/18/26 admission to the facility. Resident #6 could not recall the incident or if s/he hit their head, however, Resident #6's neurological exam was abnormal, so s/he was sent to the emergency room. S/he was diagnosed with a subdural hematoma (a life-threatening collection of blood that builds up between the surface of the brain and the dura mater).Upon readmission to the facility on 5/31/26, Resident #6 was moved to a bed closer to the nursing station to prevent falls according to a nursing note completed on 5/31/26 at 6:40 PM by RN #5. However, there was nothing in the care plan noting this intervention was in place and multiple observations over the course of the survey from 6/16/26 through 6/19/26, Resident #6 was noted in his/her room with the door closed, or if the door was open, the curtain was pulled so the residents' activities were still not visible to the staff in the hall or sitting at the nurses station. This surveyor noted Resident #6 awake during these time frames. This surveyor spoke to him/her on 6/17/26 at 7:00 AM when the curtain was noted closed and remained closed until morning cares were finally completed after 10AM.The care plan that was initiated upon the residents return on 5/31/26 noted one for poor safety awareness and falls, with interventions for physical therapy, proper footwear and orienting the resident to the call bell. During this survey and review, Resident #6 was no longer in physical therapy and was noted with the wrong size foot wear during care observations on 6/17/26. S/he did have the call bell, however, no other interventions or changes were added to the residents plan of care since the previous falls for the prevention of further falls and injuries. After the hospitalization for the fall that resulted in the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	subdural hematoma, Resident #6 fell again on 6/2/26 out of the wheelchair at the nurses station with abrasion documented to left knee.Attending #21 was interviewed on 6/18/26 at 11:11 AM. Her notes, the contents and the resident status at the time the notes were written were reviewed with her as she concurrently reviewed the same notes from 6/1/26 specific to Resident #6's readmission and a 6/17/26 note. She stated that she was aware of the incident with the subdural hematoma with Resident #6. She further stated that her notes were incorrect as she noted Resident #6 had ?no initial acute injury,' and that a subdural hematoma is a major injury. Further the expectations of 24/7 supervision in her notes were explained. She expected staff to have the resident visual, either at the nursing station or visually monitoring him/her. This surveyor reported to her that the surveyors were arriving prior to 7:00 AM over the past few mornings and since the start of observations on 6/16/26, the surveyors have observed Resident #6's door closed, even after breakfast was served in the morning, the curtain was pulled so the resident was not visible. Attending #21 verbalized at this time that that was a concern. The lack of actual orders in place for safety measures related to Resident #6's falls was discussed at this time.A general progress note completed on 6/3/26 stated that an IDT meeting was held and recommended Resident #6 to have physical and occupational therapy. However, 2 days later on 6/5/26 Resident #6 was released from therapy secondary to insurance reasons. No further interventions were put in place for the prevention of falls for Resident #6.The identified concerns were brought to the attention of the NHA throughout the survey. She stated on 6/18/26 at 8:48 AM that IDT meets on Wednesdays and it is up to the individual disciplines i.e. nursing, dietary, social work, to update their respective care plans. The concern that the care plan when established failed to address the specific individualized needs of the resident was reviewed at this time.When the DON was notified of the concern on 6/18/26 at approximately 1:00 PM she stated that she thought there was communication from the family about leaving the door closed. However, as of 6/24/26 this was not provided to the survey team and was not reflected in the resident's plan of care. The concern that a resident was admitted to the facility with a known history of falls with injuries and the facility failed to have appropriate individualized interventions in place for said resident who continued to have multiple falls resulting in an actual injury was reviewed with the facility on 6/18/26 and again on 6/22/26.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on medical record review and interview with facility staff, it was determined that the physicians failed to have their signed notes in the medical record timely after seeing the resident and ensure their notes were individualized and reflected the status of the resident. This was evident 1 of 2 (Resident #7) residents reviewed during a complaint survey.The findings include: 1. Review of the medical record for Resident #7 on 6/18/26 at 10:29 AM revealed attending notes completed by attending #21 completed on 5/20, a history and physical, 6/1 and 6/17.All 3 notes contained the same information. On 5/31/26 Resident #7 sustained a fall and acquired requiring hospitalization where it was noted that s/he acquired a subdural hematoma. The 6/1/26 readmission note stated that Resident #7 had ?no acute injury.' To plan for 24/7 supervision. Attending #21 was interviewed on 6/18/26 at 11:11 AM. Her notes, their contents and the resident status at the time the notes were written were reviewed with her as she concurrently reviewed her notes. She stated that she was aware of the incident with the subdural hematoma. After reviewing what was brought to her attention by the surveyor, she stated that it was her ?fault,' that it was not a comprehensive note capturing the resident's actual status and that she would be more careful in the future. 2. During the review of these progress notes it was also identified that these progress notes for this resident had a different created and signed date. Review starting on 6/16/26 at 8:21 AM revealed the following:Physicians' notes from 5/20/26 (history and physical) were signed on 5/24. The 6/1/26 (readmission post hospitalization for significant injury) note was not signed until 6/10/26 and the 6/17/26 (readmission post hospitalization for infection) progress note was signed the next morning on 6/18/26. Therefore, had there been any changes or updates to the resident care it would not have been implemented until the signed date, not the day the physician initiated the progress note potentially causing delays in care.