STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215082	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Pikesville	7 Sudbrook Lane Pikesville, MD 21208

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interviews with residents and facility staff and record reviews, it was determined the facility failed to ensure that residents choices for discharge were properly facilitated by the facility staff. This was found to be evident for 2 (Resident #17 and #91) out of 4 residents reviewed for Choices during the facility's survey. Findings include: 1. An interview was conducted with Resident #17 on 6/11/25 at 1:20 PM and the resident was asked the question, if s/he can make choices about their daily life. The resident stated that s/he would like to have a private place to live. The resident went on to say that s/he would like to have family and friends visit where there is privacy, no restrictions and can go outside and get fresh air whenever s/he desires. Resident # 17 stated that s/he would like to be in a place where there are healthy and highly functioning people like him/her, and not in a place surrounded by people who are much older. The resident went on to say that the discharge process was started three times previously and not completed due to staff leaving, and that s/he and other residents are waiting for assistance with discharge. An interview was conducted with the Director of Social Worker (DOSW) (#8) on 6/11/25 at 2:00 PM and she was asked about Resident #17's discharge plans and if she was aware of the resident desire to be in a setting that allowed the resident to have his/her own privacy. The DOSW stated that she has only been in her position for thirty (30) days. She stated that she will follow up with the resident. 2. An interview was conducted with Resident #91 on 6/13/25 at approximately 11:00AM and S/he said to the surveyor that s/he would like to leave the facility but has not been able to get assistance with this process. The resident further stated that s/he is highly functioning and would like a place of their own. The resident stated that no one has followed up for months. An interview was conducted with the Nursing Home Administrator on 6/13/25 at 9:25 AM he confirmed that the current DOSW (#8) has been working at the facility for approximately 30 days. He confirmed that the previous Social Worker (SW) last day of work was on 1/17/25. The Administrator told the survey team that a consultant was providing services to the facility once a month. (continued on next page)

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
	215082	A. Building B. Wing	06/18/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another interview with DOSW #8 on 6/13/25 at 2:00 PM she stated to the survey team that she was currently working with both residents and that both Residents #17 and #91 were highly functioning and in stable health. She provided documentation of a previous social work note for Resident #17 dated October 2024 and a previous social work note dated 11/26/24 for Resident #91. She told the survey team that she was unable to provide follow-up social work documentation for Resident #17 and #91 during the absence of the previous social worker who left in January 2025. All concerns were discussed at the exit conference on 6/18/25 at approximately 2:00 PM.

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	215082	A. Building B. Wing	06/18/2025

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record reviews and staff interviews, it was determined that the facility failed to provide Medicare beneficiaries with 1) Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage and 2) Notice of Medicare Non-Coverage. This was evident for 2 (Residents #50 and #72) out of 3 residents selected during the Beneficiary Protection Reviews. The findings include: The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage form (CMS-10055) provides information to residents/beneficiaries that services may no longer be covered by Medicare and addresses the resident's liability for payment should they wish to continue receiving the skilled services. The Notice of Medicare Non-coverage form (CMS-10123) informs the beneficiary of his/her right to file an appeal of the decision and the right to an expedited review of Medicare non-coverage of services. 1) On 06/17/25 at 11:58 AM, a review of the SNF Beneficiary Protection Notification Review form (CMS-20052, completed by the facility, indicated that Residents #50 and #72 were not provided with the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage form (CMS-10055). The facility checked the box for the option that stated *If NOT issued and should have been: F582. On 06/17/25 at 12:10 PM, the Nursing Home Administrator #1 was interviewed. During the interview, the surveyor informed Administrator #1 that the SNF Beneficiary Protection Notification Review form (CMS-20052), for Residents #50 and #72, indicated that Residents #50 and #72 were not provided with the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage form (CMS-10055), and that the option, which stated *If NOT issued and should have been: F582, was selected. In response, Administrator #1 indicated that Residents #50 and #72 were not provided with the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage form (CMS-10055). 2) On 06/17/25 at 11:58 AM, a review of the SNF Beneficiary Protection Notification Review form (CMS-20052), completed by the facility, indicated that Resident #72 was not provided with the Notice of Medicare Non-coverage form (CMS 10123). The facility checked the box for the option that stated *If NOT issued and should have been: F582. On 06/17/25 at 12:10 PM, Administrator #1 was interviewed. During the interview, the surveyor informed Administrator #1 that the SNF Beneficiary Protection Notification Review form (CMS-20052), for Resident #72, indicated that Resident #72 (continued on next page)

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	215082	A. Building B. Wing	06/18/2025

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not provided with the Notice of Medicare Non-coverage form (CMS-10123), and that the option, which stated *If NOT issued and should have been: F582, was selected. In response, Administator #1 indicated that Resident #72 was not provided with the Notice of Medicare Non-coverage form (CMS-10123).

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	215082	A. Building B. Wing	06/18/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations and interviews, it was determined that the facility failed to maintain a clean, in good repair and functional environment and building. This was evident during observations made on the 1 [NAME] Wing of the facility and resident room [ROOM NUMBER] during the survey. The findings include the following: During observation rounds on 06/11/2025 at approximately 12:45 PM with Environmental Service Director staff #6 and Maintenance Director staff #5, the facility housekeeping closet located on 1 west wing was found to have approximately 2 inches of standing water, dark green and black in color, in the floor drain area with a smell of musty, earthy, and decaying wood pungent odor. Staff #6 verified the observation and stated that the drain was clogged, and the drain area and pipes need to be cleaned. During observation rounds and interview on 06/11/2025 at approximately 12:50 PM with Maintenance Director staff #5 the facility utility room located on 1 west wing was found to have a toilet bowl filled with dark green and brown colored water with a smell of musty, earthy, pungent odor. Staff #5 stated that this toilet should not have old water in it and should be clean. During observation rounds and interview on 06/11/2025 at approximately 12:55 PM with Maintenance Director staff #5 the facility medication room located on 1 west wing was found to have a sink with a dark green and reddish - brown in color flaky substance located around, inside and at the base of the sink drain. It was also noted that there were no paper towels or similar items within the room for staff to use to properly wash their hands. Staff #5 stated that staff do use the room as a resident medication room and the sink would be cleaned or replaced as well as paper towels will be available to staff when washing their hands. During observation rounds and interview on 06/12/2025 at 10:00 AM with the Nursing Home Administrator staff #1 in resident room [ROOM NUMBER], the bathroom was noted to have a toilet with a cracked water tank, a green, white and black colored hard substance on the toilet handle, and a bed side commode over the base of the toilet with a reddish-brown flaky substance over the front and legs of the bed side commode. Staff #1 was shown and made aware of observations by surveyor.

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	215082	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Pikesville	7 Sudbrook Lane Pikesville, MD 21208

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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 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. Based on administrative record review and interviews with facility staff it was determined the facility staff failed to report allegations of abuse immediately. This was found to be evident for Resident #19 out of 5 intakes reviewed for abuse allegations during the facility's survey. Findings include: MD00206887 was reviewed on 6/16/25 at 10:00AM for allegations of abuse to Resident #19. According to the facility's investigation, and a statement by GNA #21, it indicated that she witnessed a Nurse #22 verbally and physically abuse the resident. Further review of the investigation found that the GNA (#21) did not report this allegation immediately. Abuse was unsubstantiated. An interview was conducted with the Administrator and the Director of Nursing on 6/16/25 at 4:00PM and the Administrator was asked to explain what the expectation of staff is when abuse is witnessed, and he stated the following: The staff member is to immediately tell someone in management about it. He went on to say that all staff are trained during onboarding and that GNA (#21) was expected to adhere to these guidelines. The Administrator further stated that the Nurse #22, the alleged perpetrator and the GNA #21 had conflict with each other prior to her reporting this and that it may have been retaliation to being reprimanded by the nurse #22. The Administrator reported to the survey team that the abuse allegation was unsubstantiated and that the nurse was terminated for openly discussing the abuse case during the investigation, and the GNA resigned. The Administrator confirmed that the GNA was to report the abuse allegations immediately.

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	215082	A. Building B. Wing	06/18/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) On 06/13/25 at 02:07 PM, Resident #97's record was reviewed. The record review revealed that Resident #97's Care Plan Conference Summary sheet, dated 04/28/25, indicated that the Activities Director #26, Unit Manager (Licensed Practical Nurse) #4, Dietician #27 and Social Work Director staff #8 were the only interdisciplinary team members who participated in updating Resident #97's care plan on 04/28/25. According to Resident #97's Care Plan Conference Summary sheet, dated 04/28/25, the attending physician as well as a registered nurse and a nurse aide, with responsibility to the resident, did not participate in updating Resident #97's care plan on 04/28/25. Also, the facility did not provide the surveyor with documentation indicating that the attending physician, registered nurse and nurse aide communicated their updates to Resident #97's care plan. On 06/13/25 at 03:28 PM, staff #8 was interviewed. During the interview, the surveyor made staff #8 aware that, according to Resident #97's Care Plan Conference Summary sheet dated 04/28/25, that the attending physician as well as a registered nurse and nurse aide, with responsibility to the resident, did not participate in updating Resident #97's care plan on 04/28/25. Staff #8 mentioned that she would check Resident #97's progress notes for documentation communicating the attending physician's, registered nurse's and nurse aide's updates to Resident #97's care plan. Based on record review and interviews, it was determined that the facility failed to develop 1) a resident comprehensive care plan within 7 days after completion of a comprehensive assessment by the entire interdisciplinary team (IDT) and 2) a care plan that was prepared and revised by the entire interdisciplinary team during the resident's quarterly review assessment. This was evident for 2 residents (Residents #4 and #97) out of 14 residents reviewed during the survey. The findings include: An Interdisciplinary Team (IDT) in healthcare is a group of professionals from different disciplines who collaborate to provide comprehensive care for a resident. Per federal regulation, it states an IDT, that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, to the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. And other appropriate staff or professionals (continued on next page)

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	215082	A. Building B. Wing	06/18/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in disciplines as determined by the resident's needs or as requested by the resident. 1) During resident record review on 6/13/25 at 01:50 PM for Resident #4, it revealed that resident was admitted on [DATE], a comprehensive assessment completed on 4/10/25, and a comprehensive care plan completed on 4/28/25, which was not completed within 7 days of the comprehensive assessment. 2) During resident record review on 6/13/25 at 1:55 PM for Resident #4, it revealed a care plan conference summary dated 4/28/25; 'The Care Plan Element, Discussed with Resident/Resident Representative and Comments' sections blank; the 'Summary of Care Plan Conference Discussion' section noted to say 'no answer from son or daughter'; and the 'All Care Plan Conference Attendees Must Sign Below' sections with signatures from the Director of Social Work #8, Director of Activities #26, and Dietician #27. The resident record review also revealed a 'Care Plan Note' dated 4/28/25 created by LPN/Unit Manager #4 which noted a failed attempt to reach Resident #4 son or daughter for the care plan meeting. The resident record failed to identify a comprehensive care plan that was prepared by a full IDT team to also include the attending physician, and a registered nurse and nurse aide with responsibility for the resident. During an interview on 06/12/25 at 11:01 AM the surveyor discussed with Social Worker #8 regarding multiple concerns stated by Resident #4 of not being aware of his/her care plan goals, planning, and not being present. Staff #8 acknowledged Resident #4 history of multiple concerns with regards to his/her plans of care. When asked about the comprehensive care plan development and plans, Staff #8 noted that there was limited documentation to support a fully developed plan by the full IDT team. Staff #8 would later provide the care plan conference summary of the meeting held on 4/28/25, however stated there was no documentation of full team participation in the formulation of goals for Resident #4. During an interview on 06/13/25 at 03:45 PM the surveyor discussed with the Director of Nursing #2 regarding the failure to demonstrate a comprehensive care plan that was prepared by an IDT team as required. DON #2 acknowledged this documentation was not present.

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	215082	A. Building B. Wing	06/18/2025

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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. Based on observation, record review, and interview it was determined that the facility failed to ensure that residents were free of significant medication errors as evidenced by facility staff failing to administer medications in accordance with professional standards. This was evident for 1 (#127) of 4 residents reviewed for medication administration.The findings include:Medication is to be administered according to the five rights of medication administration: right person, right medication, right route, right dosage, and right time.On 6/13/2025 at 11AM, a review of MD00188741 revealed that Resident #127's medications were not given as prescribed by the physician.A record review of Resident #127's medication administration audit for 2/6/23 revealed Resident #127 had received his/her medication late.On 2/6/23, the following medications were administered outside the 1-hour time frame:1. Garlic orals give 100 mg by mouth one time a day. It was scheduled for administration at 9AM, however this medication was administered outside the 1-hour time frame and administered at 3:30 PM.2. Hydralazine HCL oral tab 50 mg give 1 tablet by mouth three times a day. It was scheduled for administration at 10 AM and 6 PM, however this medication was administered outside the 1-hour time frame and administered at 11:50 AM and 8:30 PM.3. Zinc tablet 50mg by mouth one time a day. It was scheduled for administration at 10AM, however this medication was administered outside the 1-hour time frame and administered at 11:50 AM.4. Magnesium oxide tablet 400 mg by mouth one time a day. It was scheduled for administration at 10 AM, however this medication was administered outside the 1-hour time frame and administered at 11:50 AM.5. Naproxen 375 mg by mouth Two times a day. It was scheduled for administration at 2PM and 2 AM, however this medication was administered outside the 1-hour time frame and administered at 3:30 PM and 8 AM.6. Forastor capsule 250mg give one capsule by mouth two times a day. It was scheduled for administration at 2PM, however this medication was administered outside the 1-hour time frame and administered at 3:30 PM and 8 AM.On 6/13/25 at 8:30 AM the findings were discussed with the Director of Nursing who did not have a response.

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	215082	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Pikesville	7 Sudbrook Lane Pikesville, MD 21208

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review and interviews with facility staff it was determined the facility failed to ensure that medical records were maintained and accurate. This was found to be evident for 2 (Resident #17 and #91) out of 34 residents reviewed during the facility's survey. Findings include: 1. An interview was conducted with Resident # 17 on 6/11/25 at 1:20 PM and the resident was asked the question, if s/he can make choices about their daily life. The resident stated that s/he would like to have a private place to live. The resident went on to say that s/he would like to have family and friends visit where there is privacy, no restrictions and can go outside and get fresh air whenever s/he desires. Resident #17 stated that s/he would like to be in a place where there were healthy and highly functioning people like him/her, and not in a place surrounded by people who are much older. The resident went on to say that the discharge process was started three times previously and not completed due to staff leaving, and that s/he and other residents are waiting for assistance with discharge. 2. An interview was conducted with Resident #91 on 6/13/25 at approximately 11:00AM and s/he said to the surveyor that s/he would like to leave the facility but had not been able to get assistance with this process. The resident further stated that s/he is highly functioning and would like a place of their own. The resident stated that no one has followed up for months. An interview was conducted with the Nursing Home Administrator on 6/13/25 at 9:25 AM he confirmed that the current Director of Social Work (DOSW # 8) has been working at the facility for approximately 30 days. He confirmed that the previous Social Worker (SW) last day of work was on 1/17/25. During an interview with DOSW on 6/13/25 at 2:00 PM she stated to the survey team that she was currently working with both residents and that both Residents #17 and #91 are highly functioning and in stable health. She provided documentation of a previous social work note for Resident #17 dated October 2024 and a previous social work note dated 11/26/24 for Resident # 91. She told the survey team that she was unable to provide follow-up social work documentation for Resident #17 and #91 during the absence of the previous social worker who left in January 2025. All concerns were discussed with the Administration team at the exit conference on 6/18/25 at approximately 2:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215082	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 observation rounds and interviews, the facility failed to maintain an infection prevention and control program that properly identified the isolation necessary for residents, maintain infection prevention standards during resident care, and properly store and process linens to prevent the spread of infection to residents following accepted national standards. This was evident for 5 (#15, #110, #66, #45, and #89) of 55 residents and 1 of 2 of the laundry rooms observed during survey. The findings include: Enhance Barrier Precautions (EBP): Enhanced Barrier Precautions are used as an infection control intervention that uses targeted gown and glove use during high-contact resident care activities in nursing homes to reduce the transmission of multidrug-resistant organisms (MDROs). 1. During initial observation rounds and medical record review on 06/11/25 at 07:45 AM for Resident #15 surveyor observed an Enhanced Barrier Precaution (EBP) sign present on the resident room door, however no Infection Control supplies observed near or within room for staff to use to maintain infection prevention standards for this room. Per medical record review for Resident #15, it revealed a medical order Enhanced Barrier Precautions to be maintained at all times; VRE, every shift, dated 1/19/2025. 2. During initial observation rounds and medical record review on 06/11/25 at 07:52 AM for Resident #110 surveyor observed EBP signage on the resident door of a double-occupancy room, however the surveyor was unable to determine which resident required precautions. Per medical record review for Resident #110, it revealed a medical order Enhanced Barrier Precautions to be maintained at all times, every shift for ESBL Escherichia coli in the Urine, dated 4/9/2025. 3. During initial observation rounds and medical record review on 06/11/25 at 07:55 AM for Resident #66 surveyor observed EBP signage on the resident door of a double-occupancy room, however the surveyor was unable to determine which resident required precautions. Per medical record review for Resident #66, resident was not on EBP and no medical orders revealed EBP needs. 4. During initial screening rounds on 06/11/25 at 08:02 AM for Resident #45 surveyor observed signage indicating gown and glove donning and doffing with no other infection control type signage on the resident door of a double-occupancy room, and surveyor was unable to determine which resident was to be maintained on precautions. Per medical record review for Resident #45, resident was not on EBP and no medical orders revealed for EBP needs. 5. During initial observation rounds and medical record review on 06/11/25 at 07:52 AM for Resident #89 surveyor observed signage indicating gown and glove donning and doffing with no other infection control type signage on the resident door of a double-occupancy room, and the surveyor was unable to determine which resident was to be maintained on precautions. Per medical record review for Resident #89, it revealed a medical order Enhanced Barrier Precautions to be maintained at all times, every shift dated 8/7/2024. During interview on 06/11/25 at 07:50 AM with Geriatric Nursing Assistant #25 surveyor asked how do they know which resident the EBP signage applies to in a double-occupancy room. Staff #25 stated they did not know how residents were identified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215082	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Pikesville	7 Sudbrook Lane Pikesville, MD 21208

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 06/11/25 at 08:22 AM with Infection Prevention Nurse #23 surveyor discussed infection prevention supplies for staff, EBP signage and determining which resident it applies to in a double-occupancy room. Staff #23 stated that a resident is identify by a green dot placed next to the resident name on the room door tag that requires EBP. Staff #23 was notified of various rooms with inconsistencies of green dot placement. 6. During observations on 06/17/25 at 01:37 PM in the laundry room of the facility where the clean laundry is processed, there were two cement walls with brown stains and peeling damp to touch paint noted over approximately 50% of ceiling and the cement walls, as well as a large hole in the ceiling with debris protruding from the hole. The clean laundry was noted to be folded and stacked against the effected cement walls of concern and directly below the hole within the ceiling in this room. During interview on 06/17/25 at 02:00 PM with Nursing Home Administrator #1 the surveyor discussed and made aware of laundry room conditions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215082	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Pikesville	7 Sudbrook Lane Pikesville, MD 21208

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observations and interviews, it was determined that the facility failed to ensure that Resident #83 bed mattress and bed frame were compatible. This was evident for 1 resident bed out of 25 resident beds reviewed during the survey. The findings include the following: During observation rounds on 06/11/2025 at 8:10 AM Resident #83 was found lying in bed with his/her legs dangling over a gap from the end of the bed mattress to the end of the bed frame footboard. During observation rounds and interview on 06/11/2025 at 11:20 AM, Maintenance Director staff #5, using the facility's measuring tape, measured the gap between the end of Resident #83 bed mattress to the bed frame footboard to be 8 ½ inches. Staff #5 stated that the mattress was the wrong size and did not fit the bed frame.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215082	A. Building B. Wing	06/18/2025

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to maintain an effective pest control program so that the facility is free of pests. This was evident in 1 resident's bathroom out of 25 residents' bathrooms observed during the survey. The findings include the following: During an interview on 06/11/2025 at 8:02 AM Resident #56 stated that there were many black flying bugs that fly around in the room and around his/her head while they are eating. During observation rounds on 06/11/2025 at 8:05 AM approximately 14 black in color, with wings, pests were found flying around as well as on the walls in residents' room [ROOM NUMBER] bathroom and room. During observation rounds and interview on 06/12/2025 at 10:00 AM with the Nursing Home Administrator staff #1 was shown the black in color with wings pests in resident room [ROOM NUMBER] and stated that the facility has called the pest control company to treat the room and bathroom.