STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215090	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Loch Raven	8720 Emge 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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on medical record review and facility staff interview, the facility staff failed ensure that residents, who are unable to ambulate using stairs, are able to exercise their right to have visitors during their stay when the facility's only elevator malfunctioned. This was evident for all residents who have 2nd floor rooms and are unable to ambulate the stairs. These residents were reviewed during a complaint survey. The findings include: Review of complaint 2981882 on 4/29/26 at 1:30pm and complaint 2970515 on 4/29/26 at 2:03pm revealed family members were unable to visit their family members in the facility when the facility's only elevator malfunctioned. Both of the complaints revealed that residents had family members that were unable to ambulate the stairs to visit residents when the elevator malfunctioned. On 4/27/26 at 9:30am, the surveyor reviewed incident report 2975971 which reported the malfunction of the facility's only elevator from 3/28/26 to 4/23/26. The surveyor reviewed the emergency plan provided by the facility on 4/27/26 at 11:00am. Review of the emergency plan found no way for 2nd floor residents, that are unable to ambulate using the stairs, to exercise their right to have visitors during their stay when the facility's only elevator malfunctions. The emergency plan states that residents that reside on the 2nd floor and cannot ambulate safely using the stairs should stay on the 2nd floor unless there is an emergency. On 4/30/26 at 11:30am, interview with the Administrator and the Director of Nursing (DON) regarding the emergency plan provided with incident report 2975971. The surveyor asked how would residents that reside on the 2nd floor and couldn't use the stairs safely have visitation time with family and friends. The Administrator stated that visitors could use the stairs to visit with the 2nd floor residents. The Administrator also added that residents with family members that are unable to use the stairs could be transported using the emergency chair system to the waiting visitors. The surveyor asked how many times had this chair system been used by residents being moved from the 2nd floor to the 1st floor for visitation purposes. The Administrator stated that the emergency chair system was not used because 2nd floor residents and their visitors did not require the system when the facility's elevator was malfunctioning. The surveyor also asked if there were any complaints from family not being able to visit residents on the 2nd floor when the facility's elevator was malfunctioning. The Administrator stated that he was unaware of any complaints about the facility's elevator being inoperative. The surveyor pointed out that OHCQ received two complaints from family members of residents residing on the 2nd floor not being able to visit their family member when the facility's elevator was inoperative. The surveyor also pointed out that the emergency plan does not provide a plan for visitation. The Administrator provided no additional documentation regarding the plan to provide for visitation for 2nd floor residents when the facility's elevator is inoperable.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on a review of documentation and interviews it was determined that the facility staff failed to complete a thorough investigation of incidents reported to the state agency. This deficient practice was evidenced in 2 (Resident #1 and Resident #2) of 7 investigations reviewed during the complaint survey.The findings include: 1. On 04/29/26 at 9:24 am a review of the facility's investigation regarding Resident #1 revealed the alleged incident occurred on 08/26/25 about 2 pm. The five day follow up indicated Resident #1 alleged that an employee poked 2 fingers into their face and showed them their middle finger. It was unclear who was the first point of contact concerning the alleged incident. The surveyor reviewed the statements and interviews concerning the incident.On 04/29/26 at 10:30 am during an interview with Administrator #1, the surveyor asked who completed the investigation. Administrator #1 verbalized they completed the investigation. The surveyor asked who was initially made aware of the alleged incident. Administrator #1 verbalized Corporate Representative #12 was the first point of contact about the alleged incident. The surveyor reported there was not a statement in the investigation from Corporate Representative #12. The Administrator looked through the investigation and confirmed there was no statement from Corporate Representative #12. The surveyor asked Administrator #1 to explain the process they use a complete an investigation. Administrator #1 verbalized they interview the parties involved, see if there are any witnesses, look to see who was staffed during the date the alleged incident occurred. They also interview the resident's roommate. If there were no witnesses, they interview other residents who were in proximity. 2. On 04/30/26 at 11:38 am a review of the facility's investigation concerning the self-report about Resident #2 that was submitted on 12/04/25 at 3:32 pm. Resident #2 reported that on 12/03/25 during 3:00 pm - 11:00 pm shift someone wearing blue put their hand by their face & over their mouth. GNA #9 was identified as the alleged perpetrator.On 04/30/26 at 12:24 pm a review of the staffing sheet during the time of the alleged incident revealed GNA #10 and GNA #11 worked on the unit where the alleged incident occurred. There was not a statement or interview from GNA #10 or GNA #11. Prior to reviewing the investigation, the surveyor provided Director of Nursing #2 and Regional Nurse #6 the opportunity to review the investigation to ensure all the necessary documents were available for the surveyor to review.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on medical record review and interview, facility staff failed to assess residents (#1, #11, #13, #15, and #16) for smoking safety at least once every three (3) months between comprehensive assessments. This was evident for 5 out of 10 residents reviewed for smoking safety during the facility's complaint survey. Findings include: Surveyor review of incident report 2975971 on 4/27/26 at 9:15am revealed the facility's only elevator was inoperative from 3/28/26 - 4/23/26. On 4/27/26 at 11:30am, the surveyor reviewed the facility's investigation and emergency plan for the facility when the elevator is inoperative. The investigation included a timeline of events and documentation on actions taken to address the needs of the residents affected. The investigation revealed a group of 10 residents that resided on the 2nd floor and were identified as smokers. The smoking area is located on the 1st floor and required residents that smoke and reside on the 2nd floor to have additional accommodations to ensure that these residents can ambulate safely to the smoking area. During the review of the residents that smoke and reside on the 2nd floor, the surveyor discovered that 5 of the 10 residents didn't receive a quarterly smoking assessment. Residents (#1, #11, #13, and #15) did not have a smoking assessment since May 2025. Resident #16 did not have any smoking assessments during his/her stay in the facility. On 4/28/26 at 1:15pm, the surveyor interviewed the Director of Nursing (DON) and Unit Manager #8 regarding the facility's policy on the frequency for when residents are assessed for smoking safety. Unit Manager #8 stated that residents that are identified as smoking are assessed quarterly for smoking safety. The surveyor pointed out that 5 of the 10 residents affected by the facility's inoperative elevator had not had a smoking assessment quarterly. In fact, one of the residents had no evidence of the facility providing an smoking assessment for the resident during his/her stay. The DON reviewed the resident records and confirmed the identified residents did not receive a quarterly smoking assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and interviews it was determined that the facility staff failed to complete a person-centered care plan for residents that received peritoneal dialysis (#7) and had mobility limitations (#6) . This deficient practice was evidenced in 2 (#6 and #7) of 16 medical records reviewed for person centered care plans. Findings include: 1. On 4/29/26 at 11:01am, the surveyor reviewed complaint 2981882 which alleged the facility only had one hoyer lift for all of the residents in the facility making it difficult for the resident to get out of bed at his/her desired time. Surveyor review of Resident #6's care plan on 4/29/26 at 11:12am revealed interventions for resistance to care and adjustment issues. Surveyor interview of Unit Manager #13 on 4/29/26 at 12:15pm confirmed the Resident #6 was resistant to care. The surveyor asked Unit Manager #13 about the number of hoyer lifts in the facility. Unit Manager #13 stated that each floor of the facility had two hoyer lifts. The surveyor informed Unit Manager #13 of Resident #6's concern that he/she were unable to get out of bed at a desirable time because of the lack of hoyer lifts on the 2nd floor. Unit Manager #13 denied the facility's inability to provide timely transfer of the resident from the bed to his/her wheelchair at his/her desired time. Unit Manager #13 stated that Resident #6 does not like the hoyer lift and prefers to be transferred from the bed to the wheelchair by pivoting. Unit Manager #13 further stated that the resident was prohibited from pivoting transfer from the bed to the wheelchair by physical therapy. The surveyor pointed out that Resident #6's care plan does not have interventions for the resident's resistance to the hoyer lift and his/her insistence on pivot transfer from the bed to the wheelchair despite prohibition from physical therapy. On 4/30/26 at 9:00am, the surveyor informed the Director of Nursing and Administrator of the lack of a person centered care plan for Resident #6. 2. On 04/28/26 at 11:45 am a review of Resident #7's electronic health record (EHR) revealed the resident was ordered to receive peritoneal dialysis. A review of the resident's care plans revealed the resident did not have a person-centered care plan for the peritoneal dialysis treatment. The care plan that was initiated for dialysis did not indicate what type of treatment the resident was receiving. Also, the care plan did not include when the resident was scheduled to receive the treatment or the time frames for the cycles. On 04/28/26 at 1:34 pm during an interview with LPN Unit Manager #8 the surveyor reported the resident did not have a person-centered care plan for their dialysis treatment. LPN Unit Manager #8 verbalized they never put the prescription inside of the care plan. They go to the renal care plan & click the things that would be included in the resident's care. They have a generalized care plan.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on a review of the staffing sheets and interview it was determined that the facility staff failed to include the census on the unit when the staff sheets were completed. This deficient practice was evidenced in 19 of 19 staffing sheets reviewed during the complaint survey.The findings are:On 04/30/26 at 12:24 pm a review of the staffing sheet for Unit 2 dated 12/03/25 for 3:00 pm - 11:00 pm shift revealed the census was not included on the assignment sheet. The assignment sheet was reviewed by the surveyor to ascertain which staff was working during the time of an alleged incident of abuse.On 04/30/26 at 2:15 pm a review of the staffing sheets for Unit 2 dated 12/04/25 - 12/09/25 for 7:00 am - 3:00 pm, 3:00 pm - 11:00 pm, and 11:pm - 7:00 am revealed the assignment sheets did not include the census. On 04/30/26 at 4:37 pm during an interview with Scheduling Manager #14 the surveyor asked who was responsible for completing the assignment sheets on the nursing units. Scheduling Manager #14 verbalized they were not sure who completed the assignment sheets on the units. They were not aware the assignment sheet needed to include the census. Director of Nursing #2 verbalized during the previous survey they were not told the census needed to be included on the assignment sheet.

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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 record review and interviews it was determined that the facility staff failed to document whether a resident refused a shower. This deficient practice was evident in 1 (#5) of 1 medical record reviewed for ADL care during the complaint survey.The findings include:On 04/28/26 at 12:15 pm the surveyor requested Director of Nursing #2 to provide documentation to verify Resident #5 was receiving showers. On 04/28/26 at 1:53 pm LPN Unit Manager #8 reported Resident #5 was scheduled to receive showers on Tuesday/Friday 3 pm-11 pm shift. On 04/28/26 at 2:09 pm the surveyor received copies of the shower sheets from 10/07/25, 10/10/25, 10/14/25, 10/28/25, 10/31/25, and 11/04/25. The surveyor was not provided documentation to verify the resident received a shower or bed bath on 10/17/25, 10/21/25, and 10/24/25. During an interview with Director of Nursing #2 they verbalized when a resident receives a shower it is documented on a skin sheet. The surveyor asked who ensures the showers are being provided. Director of Nursing #2 verbalized the nurse assigned to the resident, the unit manager, and they would as she collects the shower sheets. The surveyor asked where it was documented when a resident refuses a shower. Director of Nursing #2 verbalized it would be documented in the plan of care and the shower sheet when a resident refused a shower. The surveyor did not receive documentation Resident #5 received a shower or bed bath on 10/17/25, 10/21/25, and 10/24/25.