STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215209	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Overlea	6116 Belair Road Baltimore, MD 21206

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of all pertinent documents and a closed medical record, and interviews with facility staff, it was determined that the facility failed to implement preventative measures to prevent the development and deterioration of a resident's pressure ulcers. This was evident for 1 (Resident #2) out of 4 residents reviewed during a survey. The findings include: On 03/30/26 the Office of Health Care Quality received a complaint with concerns that Resident #2 was not provided with quality of care. The complaint indicated Resident #2 developed pressure wounds that deteriorated during their time in the facility.A review of CMS guidelines to prevent pressure ulcers require nursing facilities to prevent new pressure ulcers unless clinically unavoidable by ensuring proper risk assessment, implementing individualized care plans, providing necessary treatment/services, and turning bed-bound patients at least every two hours. Key measures focus on nutrition, hydration, and using pressure-reducing surfaces. Resident #2 was admitted to the facility from the hospital on [DATE] with diagnoses that include but not limited to septic shock, urinary tract infection, severe cognitive-communication deficits, an indwelling foley catheter, diabetes, anorectal cancer with a history of radiation and chemotherapy treatments, and a pressure area of the Gluteal cleft midline (coccyx area) that was being treated with Santyl ointment daily. Santyl is an FDA-approved prescription medicine used to debride (remove) dead tissue from chronic dermal ulcers and severe burns. It is the only enzymatic debrider that selectively removes necrotic tissue to promote healing. Common side effects include temporary pain, redness, or burning. The hospital staff documented a Braden score of 15 in Resident #2's hospital discharge summary.The Braden Scale is a widely used, evidence-based tool for assessing a patient's risk of developing pressure injuries. It evaluates six subscales-sensory perception, moisture, activity, mobility, nutrition, and friction/shear-with a total score ranging from 6 to 23; lower scores indicate higher risk. Braden Scale Scoring and Risk Levels - 19-23: No Risk, 15-18: Mild Risk, 13-14: Moderate Risk, 10-12: High Risk, less than 9: Severe Risk.Upon admission to the facility, Resident #2 was determined to be capable of understanding medical information and to make medical decisions by his attending physician on 11/04/25. On 11/11/25, Resident #2's was assessed by the staff to have a BIMS score of 12/15. The BIMS (Brief Interview for Mental Status) score is a 0-15 point tool used in healthcare, particularly long-term care, to assess cognitive function, with higher scores indicating better cognition. It evaluates immediate recall, temporal orientation, and short-term memory. A score of 13-15 indicates intact cognition, 8-12 moderate impairment, and 0-7 severe impairment.A review of the facility policy for Pressure Injury Prevention and Management on 04/09/26 revealed the policy was last reviewed by the Medical Director on 11/12/2025. Under the policy explanation and compliance guidelines: 2. The facility shall establish and utilize a system approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.On 04/09/26, a review of Resident #2's 11/04/25, 10:02 pm nursing admission progress notes revealed Resident #2 was assessed to be cognitively impaired, required two-person physical assistance with transfers and toileting hygiene, and an indwelling foley catheter. On 11/04/25 at 11:50 PM, Resident (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	#2 was assessed by the nurse as having an open area on his sacral area that was noted to be from moisture associated skin damage (MASD). There were no documented measurements of the MASD nor any documentation of an odor, drainage, depth of the wound. A review of Resident #2's admission base line care plan included the nursing intervention: to leave Resident #2's sacral area of MASD ota (open to air). Further review of Resident #2'closed medical record revealed three other Braden Scale assessments dated 11/06/25, 11/14/25, and 11/19/25. Each of these Braden scale assessments determined that Resident #2 had a LOW probability for developing a pressure wound.A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed).Further review of the nurses progress notes revealed that on 11/23/25 at 3:41 PM and 3:51 PM, Resident #2 was identified with 2 new pressure wounds on the weekly skin evaluation Pressure wound #1 was noted to the coccyx area and Pressure wound #2 was noted to the sacrum. The medical record failed to reveal any nursing documented measurements of the 2 new pressure wounds nor any documentation of an odor, drainage, or depth of the wound. The medical record also failed to reveal that Resident #2's physician was made aware of the 2 new wounds on 11/23/25 at 3:41 PM or 3:51 PM The nursing staff also completed a new Braden Scale assessment on 11/23/25 and determined Resident #2 to have a Braden score of 10 (high risk for pressure wound development). On 11/24/25, Resident #2 was assessed by the facility wound consultant who documented Resident #2 appeared immobile, confused, and in no acute distress but had the following wounds: the first wound was an unstageable sacral full thickness pressure wound that measured 6 cm x 3 cm x unknown depth (due to presence of nonviable tissue and necrosis). The duration of this first wound was listed to be greater than 5 days old by the wound consultant. (A full-thickness wound is a severe injury extending through the epidermis and dermis into subcutaneous tissue, often exposing muscle, tendon, or bone. Common causes include Stage 3/4 pressure injuries. These wounds require extensive healing time, often months, via contraction and epithelialization, frequently needing specialized, moisture-balanced dressings, debridement, or grafting.) Resident #2's first wound was observed with a moderate amount of Serous drainage (Serous drainage is a clear, thin, watery fluid (plasma) that is a normal part of the healing process, commonly seen in, but not limited to, the first few days after surgery or injury. It appears pale yellow or transparent and aids healing by providing nutrients to the tissue.) The wound consultant performed a surgical excisional debridement procedure to Resident #2's first wound on 11/24/25 and then gave detailed instructions to the nursing staff on the daily dressing needs. The wound consultant then documented an estimated time to heal Resident #2's sacral wound of 1-2 months. On 11/24/25, the wound consultant then described Resident #2's second full thickness pressure wound to the left buttock was a Stage 3 wound that measured 0.5 cm x 0.7 cm x 0.2 cm with no signs of infection. The duration of this second wound was listed as being greater than 5 days old by the wound consultant. The wound consultant also estimated the time to heal Resident #2's left buttock wound would be 1-2 months.Further review of Resident #2's physician and nurse practitioner progress notes from 11/04/25 through 11/24/25 failed to reveal and documentation regarding any changes to Resident #2's skin.In an interview with the facility nurse practitioner, CRNP#1, on 04/13/26 at 11:30 am, CRNP#1 stated that the medical staff had not been alerted to any skin issues regarding Resident #2 in November 2025. CRNP#1 stated the first time that they documented any issues with Resident #2's skin was on 12/10/2025. CRNP#1 stated that the facility wound consultant addressed Resident #2's skin issues before that time.In an interview with Resident #2's attending physician on 04/13/26 at 2:21 PM, Resident #2's attending stated that they were unaware of any skin (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	issues after Resident #2 was admitted on [DATE]. Resident #2's physician stated, if the nursing staff calls me about a resident's skin, I will order a treatment and get the wound consultant to see the resident. When asked, Resident #2's physician they did not recall discussing Resident #2's wounds during the monthly Quality Assurance meetings.A further review of Resident #2's care plans and nursing interventions failed to reveal any preventative nursing interventions to assist or to turn and reposition Resident #2 every 2 hours. The CNA staff were documenting yes or no if they turned and repositioned Resident #2. From 11/04/25 through 11/24/25 the CNA staff documented the following: Day shift, 7am to 3 pm, 10 of 20 days the CNA staff documented NO they did not turn and reposition Resident #2.Evening shift, 3 pm to 11 pm, 4 of 20 days the CNA staff documented NO they did not turn and reposition Resident #2.Night shift, 11 pm to 7 am, 4 of 21 days the CNA staff documented NO they did not turn and reposition Resident #2.