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	04/30/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews it was determined that the facility staff failed to ensure residents had their call bells in reach to notify the staff when assistance was needed. This deficient practice was evidenced in 5 (#5, #30, #47, #94, #97) resident observed without their call bells during the recertification survey. The findings include: During observation rounds on 04/23/25 at 8:25 AM the surveyor observed Resident #47 call bell on the floor and Resident # 30 call bell was on the other side of the room which was not in reach. Geriatric Nursing Assistant (GNA) # 27 confirmed the residents did not have their call bells. At 8:43 AM the surveyor observed Resident # 94's call bell on the floor near the left side of the bed. At 9:08 AM the surveyor observed Resident #97's call bell on the floor near the right side of the bed. At 9:10 AM the surveyor observed Resident #5's call bell on the floor on the left side of the bed. On 04/29/25 at 9:53 AM during an interview with the Assistant Director of Nursing (ADON) #1 the surveyor asked, does the management team expect the staff to ensure the residents have their call bells? ADON #1 verbalized, every resident should always have their call bells. However, from time to time the call bell can fall. The nursing staff round at least every 2 hours. If they see a call bell on the floor, the staff will raise it and ask questions regarding whether the residents need anything. ADON #1 was made aware of the surveyor's observations while performing resident rounds.

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
	215209	A. Building B. Wing	04/30/2025

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to manage his or her financial affairs. Based on record review and interview it was determined that the facility staff failed to ensure residents whose funds were managed by the facility had access to their money anytime. This deficient practice was evidenced in 94 of 94 resident accounts being managed by the facility staff. The findings include: On 04/28/25 at 11:28 AM during an interview with Business Office Manager # 31 the surveyor asked a series of questions related to the residents' ability to access their finances. Business Officer Manager #31 verbalized the normal business hours at the facility was 8:30 AM-5:00 PM Monday-Friday and he/she is available on Friday if any of the residents need money for the weekend. Prior to the Coronavirus Disease 2019 (COVID-19) pandemic the Receptionist would give the residents money. If they worked on Saturday or Sunday he/she would be available to give them money. When asked can residents access their funds on the weekend? Business Office Manager #31 verbalized nobody can access the funds during the weekend. When asked how many residents funds are being managed, Business Office Manager #31 verbalized they are managing 157 resident accounts. On 04/28/25 at 2:22 PM a review of the Trail Balance list of residents with financial accounts revealed that there were 94 open resident accounts that had a balance. During the beginning of the recertification survey on 04/23/25 the facility census was reported by the Administrator as 141 residents.

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	04/30/2025

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 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. Based on observations and staff interviews, it was determined that the facility failed to provide a clean, comfortable and homelike environment. This was found to be evident in 2 (G10 and G11) out of 11 ground floor rooms reviewed during the annual survey. The findings include: On 04/29/25 at 10:33 AM, the surveyors observed the environment of the resident's room. The room was dirty, sticky on the floor when stepped on, and the bathroom wall had brown stains smeared on the wall. On further observation, the surveyors saw that the window blinds were broken, the ceiling tiles were coming apart, the toilet pipe wasn't fixed in the wall and the wall was cracked around the pipe. The floor was cracked and broken at the joint at the entry to the bathroom. On 04/29/25 at 11:42 AM, interviews and observations were conducted with the Administrator, Maintenance Director, and Account Manager of the Healthcare Services Group (AMHSG) were conducted to review the concerns. The Maintenance Director said the facility performed some repairs and contracted out other repair work when necessary. The AMHSG, who had oversight for environmental services, acknowledged the surveyor's concerns and stated the room would be cleaned. The Administrator acknowledged the concerns and stated the facility is working on all environmental concerns.

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	04/30/2025

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 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 interview it was determined that the facility staff failed to implement a patient centered care plans for dental care and integumentary care. This deficient practice was evidenced in 3 (#25, #37, #112) of five resident records reviewed for dental and integumentary care during the recertification survey. The findings include: On 04/25/25 at 1:41 PM a review of Resident #37 electronic medical record revealed the resident did not have a care plan for dental care. On 04/28/25 at 9:21 AM a review of Resident #25 electronic medical record (EMR) revealed the resident did not have a care plan for dental care. On 04/30/25 at 11:39 AM a review of Resident #112 EMR revealed a care plan for integumentary care was not initiated although the resident is ordered to receive a skin treatment twice a day for his/her skin condition. On 04/30/25 at 11:56 AM during an interview with the Director of Nursing (DON) the surveyor asked, should Resident's #25 & #37 have a care plan for poor dentition and should Resident #112 have an integumentary care plan? The DON verbalized that each resident mentioned should have care plans. He/she would have to ask the Unit Managers why care plans for the residents were not initiated. The management team randomly review care plans on a weekly basis. Unit Managers review care plans daily and update the care plans as changes occur.

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	04/30/2025

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 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. Based on observations, medical record reviews, and interviews it was determined that the facility staff: 1) failed to clarify a physician's order, failed to monitor a resident for extrapyramidal side effects who was prescribed psychotropic medication, failed to ensure a resident received their therapeutic treatment for a skin condition, and 2) failed to follow through on laboratory monitoring recommendations. This was found evident of 3 (Resident #72, #112, and #126) out of 6 Residents reviewed for medication regimen review. The findings include: 1) During observation rounds on 04/24/24 at 11:03 AM the surveyor observed Resident #112 skin was extremely dry and scaly. A review of the resident's electronic medical record revealed the resident was diagnosed with Atopic Dermatitis. On 04/29/25 at 9:42 AM a review of Resident #112 treatment administration record (TAR) revealed the resident was ordered to receive a dermatologic cream to their skin twice a day. Further review of the order revealed the physician failed to indicate where the cream should be applied. At 1:40 PM the surveyor went to the resident's room and observed their arms were ashen and face was dry. The surveyor asked Geriatric Nursing Assistant (GNA) #27 did they apply the cream to Resident #112 skin. GNA #27 verbalized the cream was applied to the resident's skin that morning. The surveyor asked to see the cream and the GNA was unable to find the prescribed cream. The surveyor asked Licensed Practical Nurse (LPN) #30 to show the surveyor the prescribed cream. The surveyor observed LPN # 30 check the treatment cart twice and the medication cart and the cream were not available. LPN #30 verbalized the previous nurse failed to reorder the cream. The Director of Nursing was made aware the cream was not available to apply to the resident's skin and the lack of clarity to where the cream should have been applied. On 04/30/25 at 12:01 PM, during an interview with the Director of Nursing the surveyor asked what the process is to ensure that physician orders are reviewed and carried out effectively. The DON verbalized the management team goes through the order listing daily to see if they are correct. Also, they randomly pick orders for review during the morning on a weekly basis. On 04/30/25 at 8:37 AM a review of Resident #72 pharmacy recommendation dated 02/18/25 indicated there was a recommendation to monitor the resident for effectiveness and adverse consequences. The pharmacy review was signed on 02/25/25. Review of the MAR/TAR in February, March, and April revealed there was no documentation indicating the resident was being monitored for extrapyramidal side effects. On 04/30/25 at 11:25 AM the DON #2 was made aware Resident #72 was prescribed psychotropic medications (EPS) and there was a recommendation to monitor the resident for extrapyramidal side effect. The DON verbalized they did not see an order to monitor for EPS. When a resident is prescribed a psychotropic medication the standard of practice is to monitor the resident for EPS. (continued on next page)

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	04/30/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 4/29/25 at 12 noon, the surveyor reviewed Resident #126's medical record. The review revealed that an order for Resident #126 was written on 8/2/24, to take Ferrous Sulfate (iron) 325 milligrams twice daily. On further review the surveyor noted that on 3/13/25 a pharmacist completed a Medication Regimen Review (MRR) and noted that he/she made recommendations. The surveyor requested the report with the recommendations. On 4/30/25 at 9:33 AM, the surveyor reviewed the report from the 3/13/25 MRR. The recommendations were to monitor laboratory (labs) values related to iron supplement and noted the last iron lab levels were from November of 2024. The labs to monitor were, Complete Blood Count (CBC), ferritin (a protein that stores iron in the body, is measured in a blood test to assess iron stores), Total Iron Binding Capacity (TIBC) (measures the blood's ability to bind with iron), and Transferrin saturation (TSAT) (amount of iron in the blood that is bound to transferrin). A provider signed the recommendation and checked I accept the recommendation above, please implement as written. Next the surveyor reviewed the labs ordered. The review revealed the only labs ordered after the recommendation were CBC, Comprehensive Metabolic Panel (CMP), and lipid. No Ferritin, TIBC or TSAT were ordered. On 4/30/25 at 10:48 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor reviewed the concern that the recommendation for lab monitoring that the provider agreed to do was not completed. The DON stated she would follow-up and review the lab order for Resident #126 On 4/30/25 at 11:15 AM, the surveyor conducted a follow-up interview with the DON. During the interview the DON confirmed that the iron labs were missed from the lab order. She further stated that she had obtained an order to add the missed labs to the blood work that was drawn today for Resident #126 and to monitor every 3 months as recommended.

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	04/30/2025

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of Geriatric Nursing Assistant personnel files and staff interview, it was determined that the facility staff failed to conduct yearly performance reviews at least every 12 months on 3 out of 5 personnel files reviewed. The findings included: On 4/29/25 at 8:03 AM, the surveyor reviewed 5 Nursing Assistant employees' files. The review revealed that the employee files for Staff # 20, 21, and 22 (all three staff had been employed over a year) did not contain a yearly performance reviews. On 4/29/2025 at 9:21 AM, the surveyor conducted an interview with the Assistant Director of Nursing (ADON) who was also in charge of staff development. During the interview the surveyor asked if GNAs had yearly performance reviews. The ADON stated he had just started in October of last year and would follow-up. On 4/30/25 at 8:22 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA confirmed that annual evaluations of GNA were not being completed.

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	04/30/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on medication record review and interviews it was determined that the facility staff failed to act upon a pharmacy recommendation to add a dosage to a supplement prescribed to a resident. The deficient practice was evidenced in 1 (#127) of 2 pharmacy recommendations reviewed during the recertification survey. The findings include: On 04/28/25 at 10:38 AM a review of the pharmacist recommendations revealed there was a recommendation dated 02/19/25 in which the nursing staff failed to act upon. During an interview with the Director of Nursing (DON) at 12:25 PM the surveyor asked what the process is for addressing pharmacy recommendations. The DON verbalized the recommendations are received via email and the unit managers print the reviews and give them to the physicians. After they review the recommendations, the management team checks to see if there is a new order to be carried out. The form is signed and given to Medical Records to file. On 04/30/25 at 9:36 AM review of the pharmacy review dated 02/19/25 revealed Cyanocobalamin did not have strength. There are multiple doses of the supplement, but the order writes 1 tab PO QD. The pharmacy review was not signed. A dose was not added to the supplement until 04/28/25 at 1349 (1:49 PM). The Licensed Practical Nurse (LPN) #30 signed off the dose as given at 800 AM and 900 AM (500 mg). At 11:53 AM the DON verbalized they were unable to explain why the pharmacy recommendation was not addressed. The DON was made aware that LPN #30 signed off that the supplement was given twice.

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	04/30/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, and records review, it was determined that the facility failed to adhere to the professional standards of practice regarding medication storage. This was found to be evident in 2 (Ground, and 2nd floor) out of 2 medicine drawers and 1 (2nd floor) out of 2 medication storage rooms reviewed for medicine storage. The findings include: On 04/25/25 at 8:00 AM, the surveyors reviewed the medicine room with LPN # 3 on the 2nd floor. The surveyors observed a blister pack labelled Famotidine 20 mg tablet that expired on 10/26/ 2024.The surveyor verified with LPN # 3 that the medication expired. LPN # 3 stated that the drugs would be removed and returned to the pharmacy. On 4/28/25 at 08:57 AM the surveyors observed the 3rd floor medication cart with RN # 13 and found 11 loose pills. The surveyors asked where the pills came from. RN # 13 stated the pills might have fallen out of the packets and she would turn them in to Unit Manager # 4. On 04/28/25 at 11:00 AM, the surveyors observed 4 loose pills in the ground floor medication cart. LPN # 11 stated that she did not know where the pills came from. She further stated that when a loose pill is found, it is given to Unit Manager # 3.

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	04/30/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews it was determined that the facility staff failed to ensure the high temperature dishwasher's final rinse was at the temperature to sanitize the dishes and utensils at the required 180F-Fahrenheit degree temperature,and 2) failed to ensure that the foods are stored, prepared, distributed, and served in accordance with professional standards for food service safety procedures. This was evident for 11 of 11 food service and kitchen equipment in the kitchen areas noted during survey activities. The findings include: 1) On 04/23/25 at 10:15 AM, an initial tour of the kitchen area was conducted with the District Manager and the Dietary Manager. A record review of the mechanical dishwasher log revealed that the final rinse temperatures did not reach the required final rinse temperature of 180F on 04/23/2025 at 10:17 AM as indicated on the data plate by the unit manufacturer specifications. A follow up observation of the dishwasher was conducted on 04/23/2025 at 10:22 AM. The first final rinse cycle temperature measured 162F and the second final rinse cycle temperature measured 163F. On 04/23/25 at 10:40 AM, an interview with the District Manager and the Dietary Manager, revealed that the ventilation system was improperly pulling the steam out the mechanical dishwashing area which triggered the fire alarm a week prior to the survey. The staff indicated that the unit was switched to operate as low temperature washing with chemical sanitizing for the rinse cycle. A 30-gallon chlorine sanitizing bucket was observed next to the booster heater to confirm the staff statement. The surveyors observed excessive food debris, and grease build-up inside and outside the unit. The staff were notified not to use the dishwasher until it was deep cleaned and a final chemical sanitizing level must be noted on the dishwashing log for verification. On 4/23/25 at 10:44 AM, the clean dish warming carts were observed visibly soiled on the inside and outside the carts. An interview with the District Manager revealed that the units are scheduled to be deep cleaned. On 04/23/25 at 10:46 AM, surveyors observed the 3-compartment sink set-up and verified the sanitizing dispenser potency level was too strong which exceeded the 400 parts per million (ppm) level. 2) On 4/23/25 at 10:47 AM, the 3-compartment sink dump test revealed that the grease trap interceptor could not handle the flowrate of the greywater discharge, causing greywater to overflow from the top lid of the unit onto the kitchen floor. An interview with the District Manager verified that both the position of the grease trap interceptor and the elevated flowrate of the greywater discharge impeded proper drainage. Therefore, the kitchen staff were instructed to release the vats gradually, one at a time. At 10:50 AM, the Administrator confirmed that a licensed grease removal company would increase the frequency of cleaning of the grease trap interceptor. (continued on next page)

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	04/30/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/23/25 at 10:55 AM, surveyors observed a 55-gallon trashcan placed less than five inches from the ice machine and in front of a cracked wall-mounted ice scoop holder with an ice scoop in it. An interview with the Administrator revealed that the broken wall- mounted ice scoop holder was ordered and the trashcan will not be placed next to the ice machine to avoid potential cross-contamination. On 4/23/25 at 11:40 AM, surveyors observed a beverage dispenser near a food prep area. An interview with Staff #25, revealed that only one of the four bag-in--the- box beverages, which was a cranberry juice flavor, was only being used. After examination of the water line, the unit was stored in unsanitary conditions. Staff #25 confirmed that the beverage dispenser was no longer in use and will be removed from the kitchen area. On 4/23/25 at 11:51 AM a tour of the kitchen with the Maintenance Director revealed that he was unable to verify that the backflow prevention devices on the waterlines of the ice maker, coffee maker, dishwasher, mop sink, and sanitizing dispensers at the 3-compartment sink and the dishwasher have been replaced or inspected by a licensed plumber. On 4/28/25 at 2:40 PM, surveyors observed a visibly soiled non-commercial light blue portable ice chest cooler with its lid falling off the hinges, which was used to store ice for resident use, placed on top of a noticeably unclean rolling cart on the second floor. On 4/29/25 at 11:00 AM, surveyors notified Staff #10 of the broken non-commercial portable ice chest coolers located on the resident floors and requested information about cleaning schedules for the equipment. Staff #10 explained that the portable ice chest coolers got washed, rinsed, and sanitized every night. Then placed in a designated area on a stainless-steel pre-table to air dry. The kitchen staff filled the portable ice chest coolers, which were collected by one of the unit nurses each morning for delivery to their residents. The cleaning schedules were not provided to the surveyor. A follow up interview with the Administrator revealed that the broken portable ice chest cooler was removed from use in the facility. On 4/29/25 at 11:05 AM, during the interview with the Staff #10 , surveyors observed excessive buildup of dirt, dust, debris, and food spills on the wall mounted knife holder. The District Manager in training promptly removed the knife holder off the wall for cleaning and explained that a cleaning schedule would be implemented for the knife holder. On 4/30/25 at 12:20 PM, the Administrator provided the make and model number for the non-commercial portable ice chest cooler as: [NAME] model number [PHONE NUMBER]-5295-5242.

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	04/30/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations and interviews it was determined that the facility staff: 1) failed to label residents basins and urinals to prevent cross contamination of bodily fluids in shared bathrooms located on the second floor and 2) failed to ensure that the clean linens were kept separate from the contaminated linen by the use of separate rooms, closets, or other designated spaces with a closing door to provide secure methods for reducing the risk of accidental contamination within the laundry rooms. This was observed during an annual survey. The findings include: 1) During observation rounds on 04/24/25 at 8:26 AM the surveyor observed two round and 1 square unlabeled basin in the shared bathroom between Rooms 205-207 located on the second floor. There was an unlabeled urinal in the bathroom as well. The surveyor asked Geriatric Nursing Assistant # 27 how the staff deciphers which basin belongs to each resident. GNA #27 verbalized they usually write the room numbers on the basin so they could know which resident's they belong to. At 8:34 AM the surveyor observed a used urinal in a shared bathroom for the residents in Rooms 209-211. On 04/29/25 at 10:04 AM the surveyor informed Assistant Director of Nursing (ADON)/Infectious Preventionist (IP) #1 the surveyor observed unlabeled basins and urinals in shared bathrooms located on the second floor. The surveyor asked what the management expects of the staff in relation to preventing cross contamination by using another resident's personal care items. ADON/IP #1 verbalized they have spoken with supervisors and staff about the issue; it's an infection control issue. They have come in the middle of the night and discarded basins. They monitor the issue on a routine basis. Extensive education has been done with the staff. The findings include: 2) On 04/29/25 at 11:10 AM, an initial tour of the laundry areas was conducted with Staff #17. The lower corner of the drywall, which divided the dirty laundry room from the clean laundry room, revealed exposed wall frames and a gap caused by water damage. On 04/29/25 at 11:15 AM, the surveyors noted that grey water was splashing onto the drywall. This resulted in the drywall becoming saturated with the discharged grey water, with the moisture extending to the corner edge and reaching the corner ceiling. Additionally, the washing machine drain line was supported by an empty 30-gallon bucket positioned on its side, while another empty 30-gallon bucket was situated inside the floor sink. On 04/29/25 at 11:25 AM, the surveyors observed two washing machines, which showed excessive brownish and whitish residues accumulated on both the interior and exterior surfaces of the doors, door gaskets, and door handles. At 11:27 AM, Staff #17 acknowledged the significant accumulation of substances on the washing machines and agreed to thoroughly deep clean both the interior and exterior of the units to avoid potential cross-contamination. On 04/29/25 at 12:40 PM, the Administrator was interviewed about the damaged dry wall and the improper use of the empty 30-gallon buckets in the laundry rooms. The Administrator confirmed that the wall and washing machine drainpipes were already scheduled to be repaired. In addition, a properly fitted floor sink cover will be replaced to avoid greywater splashing onto the dry wall areas.

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	04/30/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility staff failed to consistently provide a clean, comfortable and home-like environment. This deficient practice was discovered during the recertification survey. The findings include: During observation rounds on 04/23/25 at 8:16 AM the clothing armoire door was hanging off in room [ROOM NUMBER]. At 8:32 AM the surveyor observed an empty bottle of Pepsi, a folded piece of paper, two small blue packs of a snack, and tissues under Resident #25's bed. At 8:41 AM the surveyor observed the toilet paper dispenser was broken and the middle light bulb was out in the shared bathroom between Rooms 213 & 215. Geriatric Nursing Assistant (GNA) #28 confirmed the surveyor's findings. At 8:47 AM the surveyor observed room [ROOM NUMBER]-B did not have a privacy curtain. At 8:50 AM the surveyor observed room [ROOM NUMBER]-B did not have a privacy curtain. At 8:53 AM the surveyor noticed the faucet was loose and the surveyor was unable to turn the water off in the shared bathroom between Rooms 208-210. At 9:03 AM, the third light on the light fixture was blown and there were stains on the wall behind the commode in the shared bathroom. At 9:11 AM the surveyor observed the third drawer was missing on Resident #121's dresser. On 04/24/25 at 10:13 AM the surveyor observed an empty bottle of Pepsi, a folded piece of paper, two blue small packs of a snack, and multiple tissues and packets of sweetener under Resident #25's bed. Some of the items were observed under the bed the previous day. On 04/29/25 at 9:58 AM the surveyor informed Assistant Director of Nursing (ADON) #1 of the observations made during the initial walkthrough of the facility. The surveyor asked ADON to explain the process in which the staff report maintenance concerns. ADON #1 verbalized there was a binder on every unit for the staff to report maintenance concerns. If there is an urgent need they are expected to call the Maintenance Director directly. They don't determine what is urgent, they just write it in the binder. On 04/30/25 at 12:22 PM during an interview with the Maintenance Director #16 and the Administrator, the surveyor asked if there was a preventative maintenance schedule in place. Maintenance Director #16 verbalized that room audits are completed depending on the issues they found. They can do 2-3 rooms a week, but they try to do a room daily. Every resident's room is audited quarterly. They have a preventive maintenance list. The maintenance assistant takes care of the problems reported in the binder. They also have TELS to report maintenance issues. The GNA's document maintenance problems in the binder and the nurses' document in TELS.