STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on record reviews and staff interviews, it was determined that the facility failed to adhere to professional standards of quality of care based on established clinical practices, physician orders, or facility policies regarding enteral feeding and medication administration. This was evident for 4 residents (Residents #9, #210, #208 and #117) out of 4 residents reviewed for professional standards of quality care during the survey. Findings include:Professional standards of quality relate to the requirement that services provided in a long-term care facility must heavily involve proper medication administration practices. This regulation is part of the Centers for Medicare & Medicaid Services (CMS) guidelines for nursing homes, and citations often occur when facilities fail to adhere to established clinical practices, physician orders, or facility policies regarding medications. Facilities must ensure that all care and services, including medication administration, adhere to accepted standards of clinical practice. This is often interpreted through established guidelines like the six rights of medication administration: right patient; right medication; right dose; right route; right time; and right documentation. 1. During observation rounds on 11/17/25 at 9:00 AM, Resident #9's tube feeding bottle was observed hanging at the bedside. The bottle was unlabeled, with no documented rate of infusion and no time indicating when it had been hung. The feeding was not running, yet the tubing remained connected to the resident's PEG site, posing a risk for contamination. When interviewed, staff #6 were unable to provide the time the feeding was started or the intended rate. Review of the facility's policy titled Care and Treatment of Feeding Tubes requires that feeding tubes be utilized in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Current standards require enteral feeding containers to be labeled with start time, rate, and resident identifiers, and that non-running feedings be disconnected to prevent contamination. These requirements were not followed. 2. On 11/20/2025 at 10:07 AM, the surveyor reviewed complaint #333113. Complaint #333113 indicated that Resident #210's medication was not administered timely. On 11/24/2025 at 3:14 PM, the surveyor reviewed Resident # 210's medical records which revealed that Resident #210's Medication Admin Audit Report indicated that the resident received the following morning medications late on 10/1/25: Hydralazine HCl 100 MG Oral Tablet, for hypertension, was scheduled for 6:00 AM and was administered at 1:21 PM; and Gabapentin 600 MG Oral Tablet, for burning in bilateral lower extremities, was scheduled for 6:00 AM and was administered at 1:21 PM. On 11/24/2025 at 3:34 PM, the surveyor interviewed staff #2. During the interview, the surveyor asked staff #2 what the expectation of staff is when administering medication to residents. Staff #2 (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
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that the expectation is that staff administer medication to residents either one hour before the medication is scheduled or one hour after medication is scheduled. 3. On November 19, 2025, at 2:45 PM, the surveyor spoke with Resident #208's wife who explained how she was upset with the facility for double-dosing her husband for 14 days. The wife explained how Resident #208 was very drowsy and looked sedated when she came to visit them. The wife was notified by the methadone program at the hospital of their denial to refill the methadone medication too soon after 12/30/24. The wife continued to explain how she had asked the nurses several times why Resident #208 was looking like that (sedated), but received no response. On 11/24/25 at 1 PM, the surveyor spoke with the Director of Nursing (DON) #2 and the Regional DON #17 about what happened with Resident #208 and their methadone dosage. The DON #2 explained that the methadone had come from the program with 2 doses in each bottle, and because the nurses were used to having a single dose in each bottle, the nurses proceeded to give them a whole bottle as their dosage instead of splitting the bottle in half. The DON #2 was asked if any grievance had been filed. The DON #2 stated yes, there was a grievance filed and completed. The surveyor asked for a copy of the grievance. The DON #2 was asked when she was made aware of the error with the medication. The DON #2 explained that she was asking for a refill on the methadone from the Methadone Clinic when the methadone was denied for being too soon for a refill. It was then deduced that a medication error had been made and that the resident had received the wrong dosage of methadone. From 11/21/24 to 12/4/24, the resident was receiving 102 mg of methadone twice a day. When the DON #2 was asked if there were any negative outcomes or adverse reactions identified with this medication error. The DON #2 responded, no. The surveyor then asked for copies of the Medication Error filed, the letter that was sent to the Methadone Clinic, the Medication Administration Records (MAR) for the methadone during November 2024, December 2024, and January 2025, and the Chain of Custody Record for each methadone order. Review of the Grievance Form revealed that on 1/2/25, Resident #208's wife complained that Resident #208 was receiving too much methadone over the last 2 weeks. The grievance was investigated by the DON #2, who concluded that a review of the resident's medication administration record should be completed and that accurate dosing and adherence to physician orders. No negative outcomes or adverse reactions were identified. The resident remained stable, and their medication regimen would continue to be monitored to ensure effectiveness and safety. The facility communicated with the prescribing methadone clinic to ensure medication packaging supports safe administration and reduces the risk of medication errors. Staff education was completed, and the methadone prescription was refilled per the physician's orders to ensure uninterrupted treatment and prevent any lapse in pain management or withdrawal symptoms. Review of the Licensed Nurse Administration Record revealed that the resident started the first dose on 11/20/24 at 10 AM. The initial order was transcribed as Methadone HCL Oral Solution 10 MG/5ML, give 25ml by mouth two times a day for opioid disorder, and should have lasted until 12/16/24. It was discontinued at 11:31 AM on 11/20/24. The next transcribed order stated Methadone HCL Oral Solution 10 MG/5ML, give 10 mL by mouth two times a day for substance abuse. Hold for systolic B/P less than 110 on dialysis days. May give after dialysis and was started on 11/20/24 at 6 PM, and again should have lasted until 12/16/24. It was noted on the Licensed Nurse administration Record that the resident did not miss any doses from 12/16/24 through to 12/30/24; however, the facility only received 14 bottles for use from 11/20 to 12/16/24. Which would have made the methadone last until 12/3/24. The resident would not have had enough to last from 12/4/24 through to 12/16/24, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	especially not through to 12/30/24 when the next refill was requested. It was also identified that the perimeters given for the systolic Blood Pressure were not being followed as the order was written. Medication was to be held for any Systolic Blood Pressure less than 110. On the following 8 dates, these instructions were not met: 12/14, 12/19, 12/20, 12/21, 12/25, 12/28/24 and 1/11/25, and 1/20/25. The methadone was not held or any note written that the provider was notified of the low systolic blood pressure. Review of the Chain of Custody Record revealed that the facility had received 28 doses of Methadone to be used from 11/20/24 to 12/16/24. The record also states that there is 102 mg (1st dose split) in each bottle, with 14 bottles received. It was documented on the form that Resident #208 was receiving one dose a day from 11/21/24 to 12/16/24. However, Resident #208 only signed off on 11/20/24 through to 12/2/24 that they received the methadone. From 12/3/24 through 12/16/24, the form was only documented by the nurse giving the methadone with no resident sign-off. The next chain of custody record was not until 12/31/24, with the dosage split into separate bottles for the AM and PM dosage as requested by the DON #2 to the Methadone Program. 4. 11/18/2025 8:15 AM during initial observation and interview with resident #117, a medication cup with approximately 30 mL of light-yellow liquid was observed on the bedside table. When this Surveyor asked the resident what it was, the resident stated oh, this was my medicine I had to take; the resident was unable to state the name or reason of the medication. During this encounter, CMA Staff #15 came to the resident door peering in during our interaction; the Surveyor asked the staff member, while pointing to the medicine cup, what medication was left at the bedside, staff #15 stated that was Lactulose. Staff #15 also stated the resident does not take all of the medications at once; I come back periodically until the resident takes them all. Surveyor then went to the Medication Cart with staff #15, it was in the Dining Hall directly across from Resident #117's room; however, the cart was away from the entrance of the door and out of view of the resident. While at the medication cart with staff #15, the Surveyor observed the medication administration record of Resident #117 with staff #15, it revealed a medication time to be given of 10:00 AM and order for Lactulose Oral Solution 10 GM/15ML (Lactulose) Give 30 ml by mouth one time a day for Hepatic Encephalopathy. This order was not charted as given, despite being left unattended by staff at bedside, prior to the Surveyor's 8:15 AM observation; nearly 2 hours prior to the medication ordered time. On 11/18/2025 at 11:00 AM during interview with Director of Nursing staff #2 and Nursing Home Administrator staff #1, this Surveyor notified them of the observed medication at bedside left unattended by CMA staff #15 and the early administration. When asked if medications were ok to leave at bedside for residents to take on their own and the early timing, both the DON and NHA stated No.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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, interviews with staff and residents' families, and review of Complaints, it was determined that the facility failed to 1.) ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public; 2.) provide enough clean linen to all residents; and 3.) ensure repairs were made to a resident door and the hallways hand railings. This was evident for 5 (333137, 333135, 333139, 333141 and 333113) out of 5 complaint intakes; 2 (residents #11 and #140) out of 2 residents; and the hallway railing on the third-floor dementia unit observed for sanitary conditions during the survey. The findings include:1. On 11/20/2025 at 10:07 AM, the surveyor reviewed complaint #333113 which alleged that the facility did not have enough linen for all residents. On 11/24/2025 at 12:40 PM, the surveyor interviewed Staff member #18. During the interview, staff #18 mentioned that the facility does not have enough blankets for all the residents, and that the facility is currently in the process of ordering more blankets for the residents. On 11/24/2025 at 12:45 PM, the surveyor conducted observation rounds. During observation rounds, after the clean linen was distributed to the units, the surveyor observed only 2 blankets on the clean linen cart in the laundry room. 2. On 11/18/25 at 3:00 PM, a resident family member told surveyors that the facility was dirty and nasty and that they needed to do better with cleaning and caring for the residents. On 11/21/2025 at 1:15 PM, review of complaint intakes (#333137, #333135, #333139, and #333141) all stated that the facility was outdated, smelled foul, and was dirty. Observations during initial entrance found the facility was not well-lit, and the walls, baseboards, and railings in the hallways were dirty with old stains and spots. There were areas in the hallways that smelled of urine. The surveyor also observed that there weren't any chairs in some of the residents' rooms for visitors to sit in. On 11/24/25 at 12:32 PM, the surveyor observed that the wall behind Resident #11's bed was stained with a substance that ran down the wall. It appeared to have been there for some time; it was dry-looking. The surveyor interviewed the unit manager, Staff #9, starting with showing her the wall behind Resident #11's bed, and she acknowledged that it was something that Resident #11 had thrown on the wall. Staff #9 stated that she would have it cleaned immediately. Continued observations showed that the whiteboard at the nurse's station had black areas around the base of the whiteboard from where the black markers were being used, and the wall was also dirty with marks all around it. The surveyor notified the unit manager of the appearance of the wall around the whiteboard and the appearance of the residents' room doors with heavy impressions of scratches. 3. On 11/18/2025 at 09:08 AM the surveyor observed areas of linoleum flooring behind the third-floor clinical unit's nursing station with brown rust like stained materials, and several mis-matched linoleum pieces, as well as missing pieces of linoleum near the entrance to sitting area of the nursing station. On 11/20/2025 at 12:20 PM the surveyor observed the hand railings between rooms [ROOM NUMBERS] showed peeling paint. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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	4. On 11/21/2025 at 10:22 AM the surveyor observed a red biohazard bag inside a carboard box on the floor; dirty linen uncovered with personal resident clothing items. In the clean utility room, the surveyor observed that there were no paper towels in the towel container near the sink and there were O2 tanks both full and empty in holders on the left side of the wall, an old call bell and cord were lying on the floor. On 11/24/2025 at 4:13 PM the surveyor interviewed the housekeeping director, staff #19 regarding the environmental issues found on the third-floor clinical unit. Staff #19 stated that he does not have a schedule for stripping waxing the linoleum floors in the facility. Additionally, staff #19 stated that facility perform deep cleaning of resident rooms monthly but did not provide any documentation to support this statement. Staff #19 stated that facility utilizes the TELS system to document and report environmental issues to the housekeeping and maintenance departments. These deficiencies were discussed with the DON and Administrator prior to and during the exit conference on 11/24/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews with facility staff, it was determined that the facility failed to ensure that residents' rights to a dignified existence during meals and incontinence care for residents. This was evident for 4 residents (#4, #188, #31 and #58) of 7 residents observed for dignity during the survey. 1. On 11/20/2025 at 11:00 AM the surveyor reviewed the Dietary Meal Serving form provided by the facility. The third-floor lunch meal delivery time was listed as 11:55 AM and 12:05PM for the residents listed as needing assistance with the meal. On 11/20/2025 at 12:08 PM the surveyor interviewed the GNA #24 regarding how the residents were monitored and/or fed in the dining room during meals. GNA #24 stated that she had been employed by the facility for the past three years. GNA #24 stated that clinical staff members are assigned to take turns feeding and monitoring residents in dining room throughout the shift. Also, GNA # 24 stated that a hospitality aide usually assist with distributing water and other fluids to the residents throughout the shift, however the hospitality aide was not working today. GNA #24 stated that the three food carts are unloaded at the same time because some residents will try to take food from other resident's trays if the staff are not present to monitor the residents. On 11/20/2025 at 12:12 PM the surveyor interviewed the unit manager for the third floor, dementia unit. The unit manager stated the current census on the unit was 48 residents. The unit manager stated that the white board located across from the nurses station indicated the number of residents who required assistance with meals and which staff members were assigned to each of these residents. On 11/20/2025 at 12 noon the surveyor performed an observation round of the third-floor clinical unit and well as a dining room observation. The surveyor observed the clinical staff escorting residents to seats in the dining room. [NAME] protective aprons were in place on most of the residents in the dining room located directly across from the nursing station. On 11/20/2025 at 12:08 PM the surveyor observed the documentation on the census white board across from the nurses station that indicated which residents were identified as requiring assistance with meals as well as the number of staff members assigned to the unit. On 11/20/2025 from 12:26 PM to 12:32 PM three food carts arrived on the third-floor dementia unit and were placed outside the dining room across from the nurses station. On 11/20/2025 at 12:34 PM the surveyor spoke with the unit manager #25 and GNA #24 regarding the surveyor's observation of GNA #24 feeding resident #4 in the dining room while the GNA was standing up. The unit manager #25 stated that an in-service would be provided to the clinical staff advising them to sit in a chair while feeding residents during mealtimes. On 11/24/2025 at 12:45 PM the surveyor observed GNA #27 standing on the left side of the resident # 188 while spooning food into the resident's mouth. The surveyor observed that there was no empty chair available to staff #27 to sit on while feeding the resident. On 11/24/25 at 12:47 PM the surveyor spoke with the unit manager #25 and GNA # 27 regarding the surveyor's observation of GNA #27 standing while spoon feeding food into a resident #188's mouth. The GNA#27 stated that he was aware that staff are to be seated when feeding residents. The unit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manager #25 stated that she would re-educate clinical staff members again regarding the correct practice of sitting while feeding residents. These resident dignity concerns were reviewed with the DON and administrator prior to the exit conference on 11/24/2025. 2. An initial tour of the building was conducted on 11/18/25 at 8:00AM by the survey team. During initial screening and observations of residents and their rooms, the following concerns were identified: Resident # 31's room was observed at approximately 9:00AM and was noted to have an odor present. There was a very large brown dried area noted on the floor underneath the resident bed and to the side. The resident was present in the room and was asked if s/he needed assistance from staff with care. The resident stated that s/he received medication to help to go to the bathroom but was unable to feel or know if the medication worked. At that time the surveyor went outside the resident room and met the nurse, Staff # 21 who was giving out medications. The nurse was asked to come into the resident room to observe the area on the floor. The nurse went into the resident room with the surveyor and confirmed that there was a very large dried brown area present on the floor. The surveyor asked the nurse to pull the resident covers back and upon doing so, the resident pad had a large brown area noted and the edges were brown and dried. The nurse stated that he would get someone to assist him with changing the resident. During a follow-up observation on the same date at approximately 9:45 AM of resident #31's room, there was a blanket covering the large dried brown area on the floor. The surveyor once again asked the nurse, staff # 21, to accompany the surveyor to the resident room and he confirmed the area was covered with a blanket. At that time, he asked Environmental (EVS) staff to go in to clean the resident room. Resident # 31 was in the hallway sitting in a wheelchair at that time and dressed and clean. On 11/20/25 at 9:00AM the NHA and the DON were made aware of the observations and this being a concern. The DON stated that the resident room should have been cleaned immediately. They were also made aware that multiple complaints were submitted regarding the building having problems with maintaining sanitary environment. They stated that re-education would be provided for staff. 3. A lunch dining observation was conducted at the facility on 11/21/25 at approximately 12:05 PM of residents awaiting lunch tray arrivals in the dining room located on second floor and the following concerns were identified: At approximately 12:15 PM a food tray was delivered by dietary staff to resident # 58. The staff placed the plate of food in front of the resident and continued serving food to other residents in the dining room. Resident # 58 was observed with their body bent over and his/her face very close to the plate using his/her mouth to retrieve food from the plate. The surveyor alerted the nurse (Staff # 22) who came into the dining room at the time of the observation and the nurse then alerted Geriatric Nurse Assistant (GNA)# 11 a who was at the next table feeding another resident. GNA # 11 immediately retrieved utensils and placed them into the resident hand. Resident # 58 began eating with the utensils after setup with utensils and cuing by the GNA. All concerns were discussed with the NHA and DON at the time of observation and at the exit conference on 11/24/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure the residents were provided with a homelike environment related to their rooms. This was determined to be true for three resident rooms, # 312, # 309, and #316 on one unit during surveyor observation tours at the facility.These findings include:On 11/18/2025 at 08:45 AM the surveyor performed walking observation rounds of the third floor nursing unit. rooms [ROOM NUMBERS] were observed with dirty built up wax on the linoleum floors. On 11/20/2025 at 12:20 PM the surveyor observed room [ROOM NUMBER] had a deep gouge of missing wood on the door. The linoleum flooring in room # 312 was dirty with built up wax, in the bathroom there was a rusty bolt on the toilet, and black marks/stains within the toilet. The linoleum in the bedroom in room [ROOM NUMBER] had built -up wax and was dirty. room [ROOM NUMBER] had a broken bedside cabinet drawer with a broken handle.On 11/24/2025 at 4:13 PM the surveyor interviewed the housekeeping director, staff #19 regarding the environmental issues found on the third-floor clinical unit. Staff #19 stated that he does not have a schedule for stripping waxing the linoleum floors in the facility. Additionally, staff #19 stated that facility performs deep cleaning of resident rooms monthly but did not provide any documentation to support this statement. Staff #19 stated that facility utilizes the TELS system to document and report environmental issues to the housekeeping and maintenance departments. Prior to the exit conference staff #19 did not provide documentation of any repairs and/or cleaning of resident rooms related to the third floor rooms. These deficiencies were discussed with the DON and Administrator prior to and during the exit conference on 11/24/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 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. Based on record reviews and staff interviews, it was determined that the facility failed to review and revise the care plan after each Minimum Data Set (MDS) assessment known as required . This was evident for 1 (Resident #32) out of 2 residents selected for Dialysis review during the survey.Findings include:The Centers for Medicare & Medicaid Services (CMS) defines the Minimum Data Set (MDS) as a standardized, comprehensive assessment of all residents in Medicare or Medicaid-certified nursing homes and swing beds. It is a tool used to gather information on resident strengths and needs, develop individualized care plans, and is used for Medicare/Medicaid reimbursement and quality of care. Section N (High-Risk Drug Classes) of the MDS, is used to document the resident's medication status for injections, high-risk drug classes, and medication-related problems.On 11/20/2025 at 11:40 AM during record review of resident #32, the resident Care Plan (dated 9/11/25) revealed Resident is on Anticoagulant therapy related to cardiac disease process; Date Initiated: 06/06/2023; and Revision on: 09/15/2025. However, further record review revealed no current anticoagulant therapy orders. The resident's last anticoagulant therapy (Heparin) was ordered on 10/15/24 and discontinued 2/4/25; the Care Plan was not updated to reflect this change, despite the MDS properly reflecting the change during 3 cycles of reviews.On 11/20/2025 at 12:08 PM during record review of resident #32, this Surveyor reviewed the Minimum Data Set (MDS), Section N (High-Risk Drug Classes), which is used to document the resident's medication status for injections, high-risk drug classes, and medication-related problems. It revealed an answer of ?Yes' indicating that the resident was receiving Anticoagulant therapy on the 9/13/24: Annual and 12/14/24: Quarterly assessments. Additionally, after the Heparin orders were discontinued on 2/4/25, the MDS, Section N was then answered ?No' during the 3/16/25: Quarterly, 6/16/25: Quarterly, and 9/14/25: Annual assessments for Anticoagulant therapy.On 11/21/2025 at 12:21 PM during an interview with LPN Unit Manager staff # 14 and MDS Coordinator staff #23, when asked who is responsible for discontinuing or updating the resident care plan, MDS Coordinator staff #23 stated the unit manager is responsible for updating the Care Plan with any changes. The Surveyor then asked, how are medication orders and care plan changes monitored; the Unit Manager staff #14 stated orders are ran every 24hrs by the Unit Manager and Care Plan discussions and updates are done weekly on the unit. When asked if this Care Plan accurately reflected the current Anticoagulant therapy, the Unit Manager staff #14, agreed No.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations and interviews, it was determined the facility failed to 1.) maintain up-to-date activity calendars in the residents' rooms; 2.) ensure the residents received activities that addressed the specific preferences and/or stimulation requested by family members of a dependent resident; and 3.) demonstrate that consistent activity services were provided and documented. This was evident for 3 (Residents #6, #101, and #1) residents out of 17 residents reviewed for Activities during the survey.The findings include:1. On 11/18/2025 at 8:21 AM, during the tour of the facility, the surveyor observed an outdated activities calendar in Resident #6's room. The calendar was from September 2025. On 11/19/2025 at 9:45 AM, during observation rounds, the surveyor observed an outdated activities calendar in Resident #6's room. The calendar was from September 2025. On 11/20/2025 at 8:41 AM, during observation rounds, the surveyor observed an outdated activities calendar in Resident #6's room. The calendar was from September 2025. On 11/20/2025 at 9:57 AM, the surveyor interviewed the Activities Director staff #4. During the interview, the surveyor made staff #4 aware that Resident #6's activity calendar was outdated. Staff #4 stated that she would update the resident's activity calendar. 2. On 11/18/2025 at 8:21 AM, during the tour of the facility, the surveyor observed an outdated activities calendar in Resident #101's room. The calendar was from October 2025. On 11/19/2025 at 9:48 AM, during observation rounds, the surveyor observed an outdated activities calendar in Resident #101's room. The calendar was from October 2025. On 11/20/2025 at 8:43 AM, during observation rounds, the surveyor observed an outdated activities calendar in Resident #101's room. The calendar was from October 2025. On 11/20/2025 at 9:57 AM, the surveyor interviewed the Activities Director staff #4. During the interview, the surveyor made staff #4 aware that Resident #101's activity calendar was outdated. Staff #4 stated that she would update the resident's activity calendar. 3. On 11/18/2025 08:29 AM the surveyor observed resident #1 in bed on the vent unit. The resident's Brief Interview for Mental Status assessment score was 15, which indicates intact cognition and was able to nod his/her head yes or no for simple questions. The surveyor observed an outdated activity calendar (October 2025) posted in the resident's room. On 11/19/2025 at 09:30 AM and 11/20/25 at 9:45 AM observations revealed the facility failed to display an up-to-date activities calendar on the resident's wall. On 11/21/2025 at 11:30 AM the facility provided an up-to-date activities calendar on the wall in the resident's room. The administrator provided copies of the once per week musical encounters 1 to 1 session during visits with the vent residents. The documentation regarding musical encounters did not specify which specific resident received the musical experience on a specific date and time or the response of the resident to musical activity. The concerns for activities were reviewed during the prior to and during the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews of facility staff it was determined the facility failed to ensure that a resident received appropriate supervision during care. This was found to be evident for 1 (Resident # 80) of 2 residents reviewed for accidents during the survey conducted at the facility.Findings include,Resident # 80 was admitted to the facility with the following but not limited diagnosis: Marfan Syndrome (Genetic Disorder that affects the body's connective tissue, which supports bones, muscles, blood vessels and other organs), and Anoxic Brain Damage.A medical record review was conducted on 11/21/25 at 11:03 AM and it revealed the resident had a fall on 8/22/25. Review of the facility's fall investigation revealed that the resident's assigned GNA stated that the resident rolled out of bed while she was cleaning the resident. Resident was assessed and did not have any injuries.On the same date the resident fall care plan was reviewed, and it revealed the resident had an actual fall and was at high risk for falls related to paralysis, immobility with spontaneous autonomic movement. Date initiated 5/25/20. Interventions include the following: Two person assist with transfer, repositioning per MDS/Care plan.An interview was conducted with the DON on 11/21/25 at 12:05 PM and she was asked to explain how the resident fell out of bed. The DON explained that the GNA pulled the resident towards her to reposition the resident to wipe the resident's back. The GNA then went to the other side and when she pulled the resident towards her the resident rolled onto the floor. The DON stated that the resident was known to have spontaneous movements. The surveyor asked the DON did the resident require the assistance of one or two staff and the DON stated that only one staff member was required at the time. The DON confirmed that the GNA provided care alone. The DON was made aware that of the resident fall care plan, and that the resident was a fall risk due to spontaneous movements and required 2-person assistance for bed transfers and repositioning, initiated 5/25/20. The DON stated that re-education will be provided for staff.All concerns were discussed with Administration during the exit conference on 11/24/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure safe enteral feeding practices by failing to: 1) ensure a resident's tube feeding was properly labeled with the rate of infusion; and 2.) ensure the time the feeding was hung and an inactive feeding setup was disconnected from the resident's PEG site to prevent potential complications of enteral feeding and to maintain dignity. This was evident for 3 (residents #9, #66 and #87) of 7 residents observed on tube feeding on during the survey. Findings include:A PEG tube, or Percutaneous Endoscopic Gastrostomy tube, is a feeding tube that is inserted through the abdominal wall directly into the stomach. It is used to deliver nutrition, fluids, and medications to individuals who cannot eat or swallow by mouth due to medical conditions. The Centers for Medicare and Medicaid Services (CMS) recommend that staff practices for handling, hang-time, and changing tube feeding bags are consistent with accepted standards of practice for infection control and manufacturer instructions. Professional standards of quality, according to the National Library of Science, Chapter 17 Enteral Tube Management-Managing Tube Clogging states, to prevent enteral tubes from clogging, it is important to follow these guidelines: flush feeding tubes at a minimum of once a shift; and flush feeding tubes immediately before and after intermittent feedings. During continuous feedings, flush at standardized, scheduled intervals. 1. During observation rounds on 11/17/25 at 9:00 AM, Resident# 9's tube feeding bottle was observed hanging at the bedside. The bottle was unlabeled, with no documented rate of infusion and no time indicating when it had been hung. The feeding was not running, yet the tubing remained connected to the resident's PEG site, posing a risk for contamination. When interviewed, staff #6 was unable to provide the time the feeding was started or the intended rate. Review of the facility's policy titled Care and Treatment of Feeding Tubes requires that the facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. The current standard of practice requires enteral feeding containers be labeled with start time, rate, and resident identifiers, and that non-running feedings be disconnected to prevent contamination which were requirements that were not followed. This deficient practice placed the resident at risk for receiving unsafe enteral nutrition, contamination of feeding equipment, and potential clinical complications. 2. On 11/18/2025 at 8:22 AM during initial observation of Resident #66, the Surveyor observed NEPRO with CARBSTEADY Tube Feed bottle hanging at bedside. The label read: 'hung at 2a on 11/18/25'. The Kangaroo OMNI Infusion Pump was in progress and the screen read: FEEDING; Intermittent Rate: 50mL/hr; Time Left: 179 mins; Feed Left 149mL; and Total Fed: 9025mL. However, at the time of the observation, the concern was the fluid level remaining in the bottle and the Time Left to be infused on the pump. The fluid remaining was approximately at 900mL level, despite the label reading that the bottle was hung at 2a for an infusion rate of 50mL; which should have infused approximately 300mL over the 6 hours, by the time of the observation. On 11/18/2025 at 2:37 PM during a follow-up observation on Day 1, the fluid level left in the same bottle observed during the initial observation now read at 800mL, again with the label stating hung at 2a on 11/18/25 and pump read FEEDING; infusing at 50mL/hr; Time Left: 1125 mins; Feed Left: 938ml, and Total Fed: 9161mL. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/2025 at 3:05 PM during follow-up observations, it revealed the fluid level left in bottle approximately 900mL, labeled 'hung at 6a on 11/19/25. The Kangaroo OMNI feeding pump read FEEDING; infusing at 50mL; Time Left: 1093mins; Feed Left: 911mL; and Total Feed: 10096mL. On 11/19/2025 at 3:23 PM during walk-through observations and interview with LPN Unit Manager staff #14, this Surveyor shared concerns of enteral feeding (Tube Feed) labeling, remaining fluid levels in the bottle, and the management of the feeding pumps. Staff #14 stated all Tube Feeds are held at 9a-1p. On 11/20/2025 11:00 AM a record review revealed the following enteral feeding orders: Enteral Feed every shift Nepro (or novasource renal if unavailable) via G-TUBE at 50 mls/hour x 20 hours/day to = 1000mls total infused. Up at 1pm; Down at 9AM or when total volume infused. AND every shift Administer H2O via g-tube/PEG at 75ml/hr times 20 hours for hydration for a total of 1500mls/day. Down when Water and Enteral feeding are infused. Enteral Feed Active10/23/2025 at 15:00. 3. On 11/24/2025 at 8:45 AM during follow-up observation of resident #87 and interview with RN Supervisor of Terrace Vent Room staff #6, this Surveyor observed the resident was connected to the enteral feed tubing and a bottle of Jevity 1.5 Cal with approximately 350mL left in bottle, labeled 'hung date: 11/23 and start time blank. At this time the Assistant DON staff #7 arrived on unit and were present during an interview with staff #6; when asked when the resident feed was completed, staff #6 stated about 8:20 AM. The Surveyor asked about the resident orders for the disconnect/down time for this resident; staff #6 stated down or when infused amount is reached. The Surveyor then asked why resident #87 was still connected to the turned off machine and concerns for resident dignity; Staff #6 stated I have not given my meds yet, I disconnect then. When asked, was this the typical policy; staff #6 stated, that's what is done, disconnect when meds is given, I do it all at the same time. The Surveyor then asked what time meds are due for this resident; staff #6 stated 10a or 9a. The Surveyor then asked will the resident remain connected to the line despite being complete; staff #6 stated, usually until meds are given. The Surveyor asked staff #6 if the Kangaroo OMNI pump was turned back on would it reveal tube feed completion information and infused amount; staff #6 stated, yes. This Surveyor, staff #6 and ADON staff #7 proceeded to Resident #87 bedside to review the last message on the pump, staff #6 turned the pump back on and it immediately revealed: 'FEED INCOMPLETE, Pump did not complete the specified feed; Feed Left: 530 mL; and Feed Volume: 1500mL. On 11/24/2025 at 9:07 AM during record review for Resident #87 it revealed the following orders: Enteral Feed every shift Jevity 1.5 (or IsoSource 1.5 is Jevity is unavaliable) via PEG at 75mL/hr x20hrs/day to = 1500mL total infused. UP @ 1PM, DOWN @ 9am or until TV is administered. Enteral Feed Active 8/13/2024 15:00. On 11/24/2025 at 10:59 AM during interview Nursing Home Administrator staff #1, Assistant DON staff #7 and DON staff #2, this Surveyor shared dignity and tube feed management concerns regarding Resident #87, resident remaining connected despite tube feed being off and feeding not fully administered based on last message of pump. This Surveyor asked if the expectation for residents to remain connected to feeding tube once the infusion is complete or during the downtime; they stated No.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews and staff interviews, it was determined that the facility failed to ensure that respiratory care, including tracheostomy care and tracheal suctioning, was provided consistent with professional standards of practice. This was evident for 4 (Residents #6, #101, #26 and #66) out of 12 residents observed with Tracheostomy tubes during the survey.Findings include:A manual resuscitator, also known as an Ambu bag, is a portable, handheld device used by trained medical professionals to provide positive pressure ventilation to patients who have insufficient or ineffective breathing. The device is essential for emergency situations, such as cardiac arrest, severe asthma attacks, or drug overdoses, to provide oxygen to a patient's lungs until more advanced medical equipment (like a mechanical ventilator) is available. 1. On 11/20/2025 at 7:38 AM, during observation rounds, the surveyor did not observe a manual resuscitator or bag valve mask in Resident #6's room. On 11/20/2025 at 7:42 AM, the surveyor conducted observation rounds Respiratory Therapist staff #5. During observation rounds, the surveyor asked staff #5 to locate the manual resuscitator or bag valve mask in Resident #6's room. Staff #5 searched through Resident #6's room for the manual resuscitator or bag valve mask. Staff #5 stated that the manual resuscitator or bag valve mask was not in Resident #6's room. On 11/20/2025 at 7:45 AM, after surveyor intervention, staff #5 placed a bag valve mask in Resident #6's room. 2. On 11/20/2025 at 7:40 AM, during observation rounds, the surveyor did not observe a manual resuscitator or bag valve mask in Resident #101's room. On 11/20/2025 at 7:44 AM, the surveyor conducted observation rounds Respiratory Therapist staff #5. During observation rounds, the surveyor asked staff #5 to locate the manual resuscitator or bag valve mask in Resident #101's room. Staff #5 searched through Resident #101's room for the manual resuscitator or bag valve mask. Staff #5 stated that the manual resuscitator or bag valve mask was not in Resident #101's room. On 11/20/2025 at 7:47 AM, after surveyor intervention, staff #5 placed a bag valve mask in Resident #101's room. 3. On 11/18/2025 during initial observation of the Terrace Unit at 8:21 AM and follow-up observation at 3:07 PM of resident #26, a resident with a tracheostomy intact with Oxygen in use, this Surveyor was unable to observe or locate a manual resuscitator/Ambu bag at bedside for potential emergent use. 4. On 11/18/2025 during initial observation of the Terrace Unit at 9:00 AM and follow-up observation at 3:17 PM of resident #66, a resident with a tracheostomy intact with Oxygen in use, this Surveyor was unable to observe or locate a manual resuscitator/Ambu bag at bedside for potential emergent use. On 11/19/2025 at 3:23 PM during observation and interview with LPN Unit Manager staff #14, this Surveyor completed a unit walk through with staff #14 and discussed the concerns of no manual resuscitator/Ambu bags available at the bedsides of residents #26 and #66. Staff #14 confirmed no (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bags were at the bedside. After Surveyor intervention, staff #14 stated the bags would be obtained from the Vent Unit. On 11/20/2025 at 7:44 AM during a follow-up observation, a manual resuscitator/Ambu bag was observed at the bedsides of both residents (#26 and #66).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on staff interviews, interviews with the family, and record review, it was determined that the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs, such as those in excessive dosage or given for an excessive duration. This was evident for 1 (Resident #208) out of 1 resident reviewed for unnecessary drugs.The findings include:On November 19, 2025, at 2:45 PM, the surveyor spoke with Resident #208's wife regarding the complaint intake. Resident #208's wife explained how she was upset with the facility for double-dosing her husband for 14 days. The wife explained how Resident #208 was very drowsy and looked sedated when she came to visit them. The wife was notified by the methadone program at the hospital of their denial to refill the methadone too soon after 12/30/24. The wife continued to explain how she had asked the nurses several times why Resident #208 was looking like that (sedated), but received no response. On 11/24/25 at 1 PM, the surveyor spoke with the Director of Nursing (DON) #2 and the Regional DON #17 about what happened with Resident #208 and their methadone dosage. The DON #2 explained that the methadone had come from the program with 2 doses in each bottle, and because the nurses were used to having a single dose in each bottle, the nurses proceeded to give them a whole bottle as their dosage instead of splitting the bottle in half. The DON #2 was asked if any grievance had been filed. The DON #2 stated yes, there was a grievance filed and completed. The surveyor asked for a copy of the grievance. The DON #2 was asked when she was made aware of the error with the medication. The DON #2 explained that she was asking for a refill on the methadone from the Methadone Clinic when the methadone was denied for being too soon for a refill. It was then deduced that a medication error had been made and that the resident had received the wrong dosage of methadone. From 11/21/24 to 12/4/24, the resident was receiving 102 mg of methadone twice a day.When the DON #2 was asked if there were any negative outcomes or adverse reactions identified with this medication error. The DON #2 responded, no. The surveyor then asked why Resident #208 had been found on the floor in their room on 11/21/24 and 11/23/24. The DON #2 explained that Resident #208 stated that they had lost their balance and slid down to the floor in front of their bed. The DON #2 was asked if the resident might have fallen because he/she was drowsy from the double-dosing of methadone. The DON #2 was unsure and stated, no. The surveyor then asked for copies of the Medication Error filed, the letter that was sent to the Methadone Clinic, the Medication Administration Records for the methadone during November 2024, December 2024, and January 2025, and the Chain of Custody Record for each methadone order. On 11/24/25 at 12:30 PM, revealed that in the progress notes, it was noted that Resident #208 had a fall on 11/21/24 and then again on 11/23/24. The progress noted did not explain in detail the condition of the resident or why they had fallen on those 2 days. Review of the Grievance Form revealed that on 1/2/25, Resident #208's wife complained that Resident #208 was receiving too much methadone over the last 2 weeks. The grievance was investigated by the DON #2, who concluded that a review of the resident's medication administration record should be completed and that accurate dosing and adherence to physician orders. No negative outcomes or adverse reactions were identified. The resident remained stable, and their medication regimen would continue to be monitored to ensure effectiveness and safety. The facility communicated with the prescribing methadone clinic to ensure medication packaging supports safe administration and reduces the risk of medication errors. Staff education was completed, and the methadone prescription was refilled per the physician's orders to ensure uninterrupted treatment and prevent any lapse in pain management or withdrawal symptoms.Review of the Licensed Nurse Administration Record revealed that the resident started the first dose on 11/20/24 at 10 AM. The initial order was transcribed as Methadone HCL Oral Solution 10 MG/5ML, give 25ml by mouth two times a day for opioid disorder, and should have lasted until 12/16/24. It was discontinued at 11:31 AM on 11/20/24. The next transcribed order stated Methadone HCL Oral Solution 10 MG/5ML, give 10 mL by mouth two times a day for substance abuse. Hold for systolic B/P less than 110 on dialysis days. May give after dialysis and was started on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/20/24 at 6 PM, and again should have lasted until 12/16/24. It was noted on the Licensed Nurse administration Record that the resident did not miss any doses from 12/16/24 through to 12/30/24; however, the facility only received 14 bottles for use from 11/20 to 12/16/24, which would have made the methadone last until 12/3/24. The resident would not have had enough to last from 12/4/24 through to 12/16/24, and especially not through to 12/30/24 when the next refill was requested.Review of the Chain of Custody Record revealed that the facility had received 28 doses to be used from 11/20/24 to 12/16/24. The record also stated that there was 102 mg (1st dose split) in each bottle, with 14 bottles received. It was documented on the form that Resident #208 was receiving one dose a day from 11/21/24 through to 12/16/24. However, Resident #208 only signed off on 11/20/24 through to 12/2/24 that they received the methadone. From 12/3/24 through 12/16/24, the form was only documented by the nurse giving the methadone with no resident sign-off. The next chain of custody record was not until 12/31/24, with the dosage split into separate bottles for the AM and PM dosage as requested by the DON #2 to the Methadone Program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, interviews with the family, and record review, it was determined that the facility failed to ensure that residents were free of any significant medication errors. This was evident for 1 (Resident #208) out of 1 resident reviewed for medication errors.The findings include:On November 19, 2025, at 2:45 PM, the surveyor spoke with Resident #208's wife regarding the complaint intake. Resident #208's wife explained how she was upset with the facility for double-dosing her husband for 14 days. The wife explained how Resident #208 was very drowsy and looked sedated when she came to visit them. The wife was notified by the methadone program at [NAME] of their denial to refill their methadone too soon after 12/30/24. The wife continued to explain how she had asked the nurses several times why Resident #208 was looking like that (sedated), but received no response.On 11/24/25 at 1 PM, the surveyor spoke with the Director of Nursing (DON) #2 and the Regional DON #17 about what happened with Resident #208 and their methadone dosage. The DON #2 explained that the methadone had come from the program with 2 doses in each bottle, and because the nurses were used to having a single dose in each bottle, the nurses proceeded to give them a whole bottle as their dosage instead of splitting the bottle in half. The DON #2 was asked if any grievance had been filed. The DON #2 stated yes, there was a grievance filed and completed. The surveyor asked for a copy of the grievance. The DON #2 was asked when she was made aware of the error with the medication. The DON #2 explained that she was asking for a refill on the methadone from the Methadone Clinic when the methadone was denied for being too soon for a refill. It was then deduced that a medication error had been made and that the resident had received the wrong dosage of methadone. From 11/21/24 to 12/4/24, the resident was receiving 102 mg of methadone twice a day.When the DON #2 was asked if there were any negative outcomes or adverse reactions identified with this medication error. The DON #2 responded, no. Review of the Grievance Form revealed that on 1/2/25, Resident #208's wife complained that Resident #208 was receiving too much methadone over the last 2 weeks. The grievance was investigated by the DON #2, who concluded that a review of the resident's medication administration record should be completed and that accurate dosing and adherence to physician orders. No negative outcomes or adverse reactions were identified. The resident remains stable, and their medication regimen will continue to be monitored to ensure effectiveness and safety. The facility communicated with the prescribing methadone clinic to ensure medication packaging supports safe administration and reduces the risk of medication errors. Staff education was completed, and the methadone prescription was refilled per the physician's orders to ensure uninterrupted treatment and prevent any lapse in pain management or withdrawal symptoms.Review of the Licensed Nurse Administration Record revealed that the resident started his first dose on 11/20/24 at 10 AM. The initial order was transcribed as Methadone HCL Oral Solution 10 MG/5ML, give 25ml by mouth two times a day for opioid disorder, and should have lasted until 12/16/24. It was discontinued at 11:31 AM on 11/20/24. The next transcribed order stated Methadone HCL Oral Solution 10 MG/5ML, give 10 mL by mouth two times a day for substance abuse. Hold for systolic B/P less than 110 on dialysis days. May give after dialysis] and was started on 11/20/24 at 6 PM, and again should have lasted until 12/16/24. It was noted on the Licensed Nurse administration Record that the resident did not miss any doses from 12/16/24 through to 12/30/24; however, the facility only received 14 bottles for use from 11/20 - 12/16/24. Which would have made the methadone last until 12/3/24. The resident would not have had enough to last from 12/4/24 through to 12/16/24, and especially not through to 12/30/24 when the next refill was requested.Review of the Chain of Custody Record revealed that the facility had received 28 doses to be used from 11/20/24 to 12/16/24. The record also states that there is 102 mg (1st dose split) in each bottle, with 14 bottles received. It was documented on the form that Resident #208 was receiving one dose a day from 11/21/24 through to 12/16/24. The next chain of custody record was not until 12/31/24, with the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dosage split into separate bottles for the AM and PM dosage as requested by the DON #2 to the Methadone Program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner to prevent the potential for food contamination. This deficient practice had the potential to affect any resident who consumes food prepared in the kitchen.Findings Include:During an observation on 11/18/25 at 9:00 AM, the following were noted in the kitchen food-service area:1. A large pile of dark black substance was observed on the floor under a shelf inside the walk-in freezer.2. The lid holder tray contained dried food residue.3. Chipping paint was observed on a post within the kitchen.4. Standing water was present on the floor near the dishwasher.5. Ten (10) ice cubes were observed spaced out across the kitchen floor.During follow-up observations on 11/19/25 at 10:00 AM and 11/20/25 at 11:00 AM, the above unsanitary conditions remained unaddressed.During an interview on 11/19/25 at 11:00 AM, the Certified Dietary Manager (CDM) (Staff #3) stated that the area should be cleaned each day. She acknowledged that the conditions observed should not have been present.After surveyor intervention on 11/21/25 at 10:00 AM, the above unsanitary conditions were addressed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, interviews with the family, and record review, it was determined that the facility failed to ensure that medical records and forms were complete and accurately documented. This was evident for 3 (Resident #208, Residents #213, and Resident #214) out of 3 resident reviewed for medical records.The findings include:1. On November 19, 2025, at 2:45 PM, the surveyor spoke with Resident #208's wife regarding the complaint intake. Resident #208's wife explained how she was upset with the facility for double-dosing her husband for 14 days. The wife explained how Resident #208 was very drowsy and looked sedated when she came to visit them. The wife was notified by the methadone program at [NAME] of their denial to refill their methadone too soon after 12/30/24. The wife continued to explain how she had asked the nurses several times why Resident #208 was looking like that (sedated), but received no response. On 11/24/25 at 1 PM, the surveyor spoke with the Director of Nursing (DON) #2 and the Regional DON #17 about what happened with Resident #208 and their methadone dosage. The DON #2 explained that the methadone had come from the program with 2 doses in each bottle, and because the nurses were used to having a single dose in each bottle, the nurses proceeded to give them a whole bottle as their dosage instead of splitting the bottle in half. The DON #2 was asked if any grievance had been filed. The DON #2 stated yes, there was a grievance filed and completed. The surveyor asked for a copy of the grievance. The DON #2 was asked when she was made aware of the error with the medication. The DON #2 explained that she was asking for a refill on the methadone from the Methadone Clinic when the methadone was denied for being too soon for a refill. It was then deduced that a medication error had been made and that the resident had received the wrong dosage of methadone. From 11/21/24 to 12/4/24, the resident was receiving 102 mg of methadone twice a day. Review of the Licensed Nurse Administration Record revealed that the resident started the first dose on 11/20/24 at 10 AM. The initial order was transcribed as Methadone HCL Oral Solution 10 MG/5ML, give 25ml by mouth two times a day for opioid disorder, and should have lasted until 12/16/24. It was discontinued at 11:31 AM on 11/20/24. The next transcribed order stated Methadone HCL Oral Solution 10 MG/5ML, give 10 mL by mouth two times a day for substance abuse. Hold for systolic B/P less than 110 on dialysis days. May give after dialysis and was started on 11/20/24 at 6 PM, and again should have lasted until 12/16/24. It was noted on the Licensed Nurse administration Record that the resident did not miss any doses from 12/16/24 through to 12/30/24; however, the facility only received 14 bottles for use from 11/20 - 12/16/24. Which would have made the methadone last until 12/3/24. The resident would not have had enough to last from 12/4/24 through to 12/16/24, and especially not through to 12/30/24 when the next refill was requested. Review of the Chain of Custody Record revealed that the facility had received 28 doses to be used from 11/20/24 to 12/16/24. The record also states that there is 102 mg (1st dose split) in each bottle, with 14 bottles received. It was documented on the form that Resident #208 was receiving one dose a day from 11/21/24 through to 12/16/24. However, Resident #208 only signed off on 11/20/24 through to 12/2/24 that they received the methadone. From 12/3/24 through 12/16/24, the form was only documented by the nurse giving the methadone with no resident sign-off. The next chain of custody record was not until 12/31/24, with the dosage split into separate bottles for the AM and PM dosage as requested by the DON #2 to the Methadone Program. 2. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage form (CMS-10055) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. On 11/18/2025 at 11:00 AM, the Entrance Conference worksheet: Beneficiary Notice – Residents discharged Within the Last Six Months form was provided to the facility. The facility completed the form and indicated that the following residents were discharged to home, residents #213 on 8/7/25 and resident #214 on 9/17/25. On 11/24/2025 at 11:00 AM, a review of the SNF Beneficiary Protection Notification Review form (CMS-20052) completed by the facility for resident #213 revealed: Medicare Part A Skilled Services Episode Start Date: 6/24/25; Last covered day of Part A service: 8/7/25; and How was the Medicare Part A Service Termination/Discharge determined?: Other (explain): Resident discharged to hospital 8/7/25. On 11/24/2025 at 2:00 PM during record review of resident #213 it revealed two discharge to home notes. A Social Service Note (dated 8/7/25 at 13:18), noted Discharge summary: [resident] is discharging home this date into [their spouse's] care. [The resident] is to receive home health services from [name of home care agency] to include pt(physical therapy), ot(occupational therapy) and skilled nursing. [The resident] has all recommended equipment at home including oxygen. [The resident] is to return to [name of medical provider] on a M, W, F 2nd shift 10:00 a.m. schedule. [The resident] should follow up with [their] primary care physician within 2 weeks of discharge. The Nurse Note (dated 8/7/24 at 14:49), noted 'Resident discharged home today with spouse at 2:43 PM. Discharge paper and prescriptions given to spouse. Resident had no pain or discomfort upon leaving.' 3. On 11/24/2025 at 11:05 AM, a review of the SNF Beneficiary Protection Notification Review form (CMS-20052) completed by the facility for resident #214 revealed: Medicare Part A Skilled Services Episode Start Date: 6/27/25; Last covered day of Part A service: 9/17/25; and How was the Medicare Part A Service Termination/Discharge determined?: Other (explain): Resident discharged to hospital 9/17/25. On 11/24/2025 at 2:05 PM during record review of resident #214 it revealed two discharge to home notes. The Discharge Summary note (dated 9/17/25 at 16:02), revealed 'Patient discharged to home at 330pm. Daughter picked patient up on w/c. All scripts and discharge instructions given to daughter. Patient left facility in stable condition'. The Social Service Note (dated 9/17/25 at 16:18), revealed Discharge summary: [The resident] discharged home this date in the care of [their] daughter who transported [them] home. [The resident] will be living with [their] son who will be provided 24/7 supervised assistance. Home health services will be provided by [name of home care agency]. [The resident] received a wheelchair from [medical equipment provider name]. [The resident] should follow up with PCP within 2 weeks of discharge. On 11/24/2025 at 2:35 PM, during interview with the Nursing Home Administrator (NHA) staff #1, the Surveyor informed NHA staff #1 that the SNF Beneficiary Protection Notification Review (CMS-20052) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forms for residents #213 and #214 indicated the residents were discharged to the hospital despite the record review for both residents and conference worksheet: Beneficiary Notice – Residents discharged Within the Last Six Months form indicating the residents were discharged home. In response the NHA staff #1 stated 'my MDS Coordinator completed the form and likely put the wrong discharge information, the residents were discharged to hospital, let me look into it'. On 11/24/2025 at 4:05 PM during a follow-up interview with NHA staff #1, the Surveyor asked for further information regarding the discharge. The NHA staff #1 stated there is no other information, the residents were discharged home.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 - Few	Provide and implement an infection prevention and control program. Based on observations and interviews with facility staff it was determined the facility failed to adhere to infection control practices and guidelines to prevent the spread of germs and cross contamination of microorganisms in the facility. This was found to be evident for 5 occurrences 1.) Resident #31 during the initial tour and screening of residents; 2.) Resident #73 during a lunch dining observation; 3.) An observation made during a tour of the laundry area; 4.) An observation of a Clean Linen bin placed within a resident-use bathroom; and 5.) The urinary catheter bag of resident #26 observed on the floor.Findings include: 1. An initial tour of the building was conducted on 11/18/25 at 8:00AM by the survey team and while screening residents and making observations of the resident rooms, the following concerns were identified: Resident # 31's room was observed at approximately 9:00AM and was noted to have an odor present. There was a very large brown dried area noted on the floor underneath the resident bed and to the side. The resident was present in the room and was asked if s/he needed assistance from staff with care. The resident stated that s/he received medication to help to go to the bathroom but was unable to feel or know if the medication worked. At that time the surveyor went outside the resident room and met the nurse, Staff # 21 who was giving out medications. The nurse was asked to come into the resident room to observe the area on the floor. The nurse went into the resident room with the surveyor and confirmed that there was a very large dried brown area present on the floor. The surveyor asked the nurse to pull the resident covers back and upon doing so, the resident pad had a large brown area noted and the edges were brown and dried. The nurse stated that he would get someone to assist him with changing the resident. During a follow-up observation on the same date at approximately 9:45 AM of Resident # 31's room, there was a blanket covering the large dried brown area on the floor. The surveyor once again asked the nurse, staff # 21, to accompany the surveyor to the resident room and he confirmed the area was covered with a blanket. At that time, he asked Environmental (EVS) staff to go in to clean the resident room. Resident # 31 was in the hallway sitting in a wheelchair at that time and dressed and clean. On 11/20/25 at 9:00AM the NHA and the DON were made aware of the observation and this being a concern. The DON stated that the resident room should have been cleaned immediately. They were also made aware that multiple complaints were submitted regarding the building having problems with maintaining sanitary environment. They stated that re-education would be provided for staff. 2. During a lunch dining observation conducted on 11/21/25 at approximately 12:05 PM the following concern was identified: GNA # 11 was observed sitting at a table feeding Resident #73 who was sitting at a table with another Resident #82, whose family was feeding the resident. The family had a wig/ hair unit lying on top of the table next to Resident #73's food. Staff # 11 continued to feed the resident while the wig/hair unit was next to the resident plate of food. The surveyor alerted the nurse; Staff # 22 and he immediately went over to the family and spoke with them. The family then removed the hair item from the table. The DON was made aware of the concerns on the same date. 3. A tour and observation was conducted in the laundry area on 11/24/25 at 12:45 PM with two (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare Post-Acute Care Center	5009 Frankford Avenue 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 - Few	surveyors, and the following concerns were identified: The entrance door into the washroom needed repair. The door was slightly ajar, appearing to not be able to close. The clean linen area that was next to the washroom was opened upon observation and the linen carts were not covered. There were multiple carts located in the linen room that had covers that were rolled up leaving the linen exposed. Further observation of the linen covers found each of the covers worn, and with exposing open areas. One cart had a large open area noted to the top of the cart. During an interview with the laundry staff # 18 on 11/24/25 at 12:45 PM she stated that the covers were old and needed to be replaced. She confirmed that the covers did not safely cover the linen during transport due to the obvious wear and tear noted. The NHA was made aware of the identified concerns on the same date at 1:30 PM. 4. On 11/18/2025 at 8:23 AM during initial observation and interviews, the urinary catheter bag of Resident #26 was observed in a dignity bag, however the bag was lying on the floor to the right side of the bed. The Nurse Supervisor staff #30 was notified immediately and was asked what the expectation was; stating the urinary bag should not be on the floor. On 11/24/2025 at 12:50 PM record reviews and interviews were completed. The Policy & Procedures for Catheter Care, Appropriate Use of Indwelling Catheter, and Infection Prevention and Control Program failed to indicate to maintain proper infection control and keep catheter bag off the floor. During interview DON staff #2, also the Infection Prevention Nurse stated, despite the Policy & Procedure specifically stating this, the expectation is to keep the bag off the floor. When asked how staff are educated; staff #2 stated they are educated to keep bag below hip level and a hook is provided to hang the bag on the bed and it is the standard of practice to maintain infection control by keeping the bag off the floor. 5. On 11/20/2025 at 9:05 AM during observations on Terrace Unit, this Surveyor observed a Clean Linen bin inside the resident room bathroom with the door closed. The LPN Unit Manager staff #14 was immediately notified while on the unit. This Surveyor then observed staff #14 remove the linen bin from the resident bathroom and place the bin in the room marked 'Clean Utility' room for further staff use on the unit; this was despite there being a room marked 'Soiled Utility' directly next door for the linens to return to Laundry to be cleaned. On 11/20/2025 at 9:10 AM during an interview with DON staff #2 & NHA staff #1, findings were shared regarding the linen bin.