

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2025
NAME OF PROVIDER OR SUPPLIER  Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Civic Avenue Salisbury, MD 21804	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on record review and interview, the facility failed to ensure 3 (Residents #47, #30, and #48) of 3 residents reviewed for dignity were treated with dignity and respect. Specifically, facility staff failed to promptly assist Resident #47 with incontinence care, which resulted in the resident attending church services in a soiled brief. Additionally, a staff member failed to knock or announce herself prior to entering the shared room of Resident #30 and Resident #48). Findings included: A facility policy titled Dignity, revised 02/2021, indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. The policy also specified, 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist resident for example: b. promptly responding to a resident's request for toileting assistance.</p> <p>1. An admission Record revealed the facility admitted Resident #47 on 03/16/2025. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke), chronic systolic heart failure, and chronic pain syndrome.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/10/2025, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident was dependent on staff for toileting and showers.</p> <p>Resident #47's care plan included a focus areas that indicated the resident was incontinent of urine and bowel. Interventions directed staff to provide perineal care as needed. The care plan also included a focus area dated as initiated 10/17/2024 that indicated Resident #47 had a general willingness to participate in group programs. Interventions directed staff to encourage the resident to utilize common areas to promote social engagement and indicated the resident's preferred activities included musical entertainment, arts/crafts, and some church.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 215067	If continuation sheet Page 1 of 45

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A form titled, Grievance Summaries dated 08/31/2025 indicated that Resident Representative (RR) #25 called the facility to report that at approximately 9:22 AM, Resident #47 experienced an episode of incontinence while preparing to attend church. The resident requested assistance with hygiene to prior to attending the service. According to the grievance, staff informed the resident that if they cleaned the resident up, they would not get the resident back up to go to church. The form indicated Resident #47 opted not to be transferred back to bed for incontinence care. The Manager on Duty (MOD) was not made aware of the incident until well after lunch. The form indicated the MOD spoke with the resident's nurse, who stated she would, have the aide address. The MOD then spoke with the resident, who concurred with the information provided by the family member. The MOD followed up with Resident #47 at 1:40 PM, at which time incontinence care had still not been provided.</p> <p>During an interview on 10/16/2025 at 10:20 AM, Resident #47 stated they had filed a grievance, with the assistance of a representative, after staff did not provide incontinence care. Per Resident #47, two staff members were needed to assist with toileting, and staff informed them that if they provided incontinence care when requested, Resident #47 would not be able to attend church. Resident #47 stated they had to attend church services in a soiled brief.</p> <p>During an interview on 10/17/2025 at 8:50 AM, RR #25 stated they received a call from Resident #47, who reported attending church in a soiled brief. According to RR #25, staff informed the resident that two staff members and a mechanical lift were required for toileting assistance, and if incontinence care were provided, Resident #47 would not be able to attend church. RR #25 expressed concern that Resident #47 attended the service without the resident's brief being changed.</p> <p>During an interview on 10/17/2025 at 9:10 AM, Certified Nursing Assistant (CNA) #39 stated that when she arrived for her shift on the date in question, Resident #47 was already up in a wheelchair, and she believed the resident had been assisted by CNA #40 and CNA #4. Per CNA #39, she was not aware of the alleged incident.</p> <p>On 10/17/2025 at 9:41 AM, Licensed Practical Nurse (LPN) #2 reported vaguely remembering a concern about staff refusing to provide incontinence care to Resident #47 for church, which was communicated by the Manager on Duty (MOD).</p> <p>On 10/17/2025 at 2:43 PM, CNA #40 stated she did not recall anything beyond assisting Resident #47 to get up. She did not recall the resident asking to be changed.</p> <p>On 10/07/2025 at 11:03 AM, the Business Office Manager (BOM), who was the MOD at the time the grievance was submitted, reported receiving a call from RR #25 regarding Resident #47, who wanted to be changed but was told that if changed, the resident would not be able to get back up to attend church; therefore, Resident #47 chose not to be changed and attended church soiled. The BOM stated she reported the incident to the resident's nurse, Licensed Practical Nurse (LPN) #2. The BOM stated it was inappropriate to tell a resident they would not be changed and have them attend church incontinent.</p> <p>On 10/17/2025 at 3:00 PM, the Interim Director of Nursing (DON) stated that providing care with dignity was essential to prevent resident embarrassment and discomfort. In the situation described, Resident #47 should have been transferred and assisted with incontinence care to attend church clean and comfortable. The DON stated the expectation was that staff seek assistance from another CNA or nurse to provide timely care so Resident #47 could attend church without delay.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/17/2025 at 3:15 PM, the Interim Administrator stated that staff were expected to provide care and that it was not appropriate for residents to be bothered or neglected in the process, like in the case of [Resident #47]. The Administrator stated the expectation was that residents attending church be clean and appropriately cared for.</p> <p>2. A facility policy titled, Dignity, dated 02/2021, indicated, 7. Staff are expected to knock and request permission before entering residents' rooms.</p> <p>During an observation on 10/07/2025 at 8:34 AM, the call light for the shared room of Resident #30 and Resident #48 was on. At 8:37 AM, Geriatric Nurse Aide (GNA) #48 entered the room without knocking or announcing herself.</p> <p>During an interview on 10/07/2025 at 8:38 AM, when informed that she entered the room without knocking or announcing herself, GNA #48 stated, The door was open. She indicated that staff did not have to knock before entering a resident's room if the door was already open.</p> <p>During an interview on 10/17/2025 at 1:21 PM, the Regional Director of Operations (RDO) stated it was his expectation that staff make themselves known before entering a room. Ideally, that meant knocking before entering, but announcing themselves before entering was also acceptable.</p> <p>During an interview on 10/17/2025 at 2:40 PM, the Regional Nurse Consultant (RNC) confirmed staff should knock before entering. It was not a facility expectation for staff to enter the room without knocking just because the door was open.</p> <p>During an interview on 10/17/2025 at 2:45 PM, Unit Manager #18 stated that staff should knock before entering. It was not facility expectation for staff to enter the room without knocking just because the door was open. She stated that staff would not enter their neighbor's home without knocking, and the residents' rooms were their homes.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>(continued on next page)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on record review, facility policy review, and interview, the facility failed to address Resident Council concerns regarding staffing and call lights for 9 of 9 months reviewed. Specifically, the Resident Council expressed repeated concerns related to call light response times and staffing, but at the time of the survey, the issues were still ongoing, indicating the facility had not sufficiently addressed them. Findings included: During an interview on 10/17/2025 at 1:21 PM, the Regional Director of Operations (RDO) stated there was no Resident Council policy. The facility's policy regarding the grievance process applied to Resident Council concerns. A facility policy titled, Grievance and Complaint Procedure, dated 01/2022, indicated, The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or complainant. The section Policy Interpretation and Implementation specified, 6. Upon receipt of a grievance or complaint, the facility administrator or designee will review and investigate the allegation and compile documentation of such findings within a reasonable timeframe of receiving the grievance/complaint. Additionally, the policy indicated, 8. The administrator and/or designee will review the findings of the investigation to determine what corrective actions, if any, need to be taken. 9. The administrator or designee will promptly inform the resident, or person filing the grievance on behalf of the resident, of the findings of the investigation and the action that will be taken to correct any identified problems. A facility document titled Resident Council Minutes, dated 01/02/2025, in the section Old Concerns, revealed No staff on weekends/Staff not getting residents up and dress[ed] and Waiting for long periods before your [call] bell is answered. Both concerns were still an issue. The section New Concerns revealed, 11 [11:00 PM] to 7 [7:00 AM] shifts sleeping not doing care. A facility document titled Resident Council Minutes, dated 02/06/2025, in the section Old Concerns revealed the following:- No staff on weekends/Staff not getting residents up and dress[ed]. The facility's response to this concern was, New staff being hire[d] weekly, addressing issue of getting all up. - Waiting for long periods before your call bell is answered. The facility's response to this concern was, Call bell response time[s] are being actively monitored and audited to ensure timely response. The call bell audits were not provided for review.- Staff not getting residents up and dress[ed] especially on the weekends. The facility's response to this concern was, All residents may get out of bed as desired. If you wish to get out of bed more frequently, please notify your charge nurse. The facility did not indicate how it would make efforts to address this concern beyond telling residents to notify the charge nurse.- 11[11:00 PM] - 7 [7:00 AM] shift not doing care. Residents must wait until the 7 - 3 [3:00 PM] shift. The facility's response to this concern was, Need clarification on station/specific nurse. Nursing leadership is conducting rounds and spot checks to ensure proper care on all shifts. No documentation of these rounds or spot checks was provided for review.- 11 to 7 shifts sleeping not doing care. The facility's response to this concern was, This must be addressed on an individual basis. If you are aware of a staff member not remaining alert during their shift or not providing care, please notify nursing leadership. A facility document titled Resident Council Minutes, dated 03/11/2025, in the section New Concerns revealed the following:- 11 - 7 shift not changing residents. The facility's response to this concern was, Please provide specifics, staff are rounding together for hand off to ensure proper care.- Nursing staff on cellphones sitting behind the nursing station not answering call bell lights. The facility's response to this concern was, No staff should be on cellphones, pop in visits have not amounted to being on cellphone, education provided. Please advise any instance in the moment via Guest Services line. A facility document titled Resident Council Minutes, dated 04/04/2025, in the section Old Concerns revealed, 11 - 7 shift not changing residents. The facility's response to this concern was, Please provide specifics, staff are rounding together for hand off to ensure proper care. A facility document titled Resident Council Minutes, dated 04/04/2025, in the section New Concerns revealed the following:- Staff still turning off call bell lights before the need is met. The facility's response to this concern was, Call bells are to be left on until any need is met. Unit managers and nursing supervisors will address with staff and monitor.- Residents are not getting up on the weekends. The facility's response to this concern was, This was addressed with specific resident and [their] RP [responsible party]. A facility document titled Resident Council Minutes, dated 05/01/2025, in the section Old Concerns revealed:- Staff still turning off call bells lights off [sic] before the need is meant [sic]. The facility's response to this concern was, Call bells are to be left on until any need is met. Unit managers and nursing supervisors will address with staff and monitor.- Residents are not getting up on the weekends. The facility's response to this concern was, This was addressed with specific resident and [their] RP A</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on staff interviews and record review, the facility failed to ensure prompt and consistent efforts were made to resolve grievances. Specifically, the facility failed to:- thoroughly investigate a grievance related to failure to provide incontinence care and inform the resident and family member who filed the grievance of the facility's efforts to resolve the grievance for 1 (Resident #47) of 3 sampled residents reviewed for grievances. - effectively and on an ongoing basis, address and make reasonable effort to follow up on and resolve repeated grievances and concerns related to staff response to call bells, as submitted by multiple residents and by the Resident Council over the past 9 of 9 months reviewed. Findings included:A facility policy titled, Grievance and Complaint Procedure, dated 01/2022, indicated, The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of resident and/or complainant. The policy also specified, 6. Upon receipt of a grievance or complaint, the facility administrator or designee will review and investigate the allegation and compile documentation of such findings within a reasonable timeframe of receiving the grievance/complaint. Additionally, the policy indicated, 8. The administrator and/or designee will review the findings of the investigation to determine what corrective actions, if any, need to be taken. 9. The Administrator or designee will promptly inform the resident, or person filing the grievance on behalf of the resident of the findings of the investigation and the actions that will be taken to correct any identified problems.</p> <p>1. An admission Record revealed the facility admitted Resident #47 on 03/16/2025. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke), chronic systolic heart failure, and chronic pain syndrome.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/10/2025, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident was dependent on staff for toileting and showers.</p> <p>Resident #47's care plan included a focus areas that indicated the resident was incontinent of urine and bowel. Interventions directed staff to provide perineal care as needed. The care plan also included a focus area dated as initiated 10/17/2024 that indicated Resident #47 had a general willingness to participate in group programs. Interventions directed staff to encourage the resident to utilize common areas to promote social engagement and indicated the resident's preferred activities included musical entertainment, arts/crafts, and some church.</p> <p>A review of Resident Council Minutes for meetings held on 05/01/2025 and 06/06/2025 indicated repeated complaints that residents were not being assisted in getting out of bed on weekends.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A form titled, Grievance Summaries dated 08/31/2025, indicated that Resident Representative (RR) #25 called the facility to report that at approximately 9:22 AM, Resident #47 experienced an episode of incontinence while preparing to attend church. The resident requested assistance with hygiene to prior to attending the service. According to the grievance, staff informed the resident that if they cleaned the resident up, they would not get the resident back up to go to church. The form indicated Resident #47 opted not to be transferred back to bed for incontinence care. According to the form, the Manager on Duty (MOD) was made aware of the incident by RR #25 well after lunch. The form indicated the MOD spoke with the resident's nurse, who stated she would, have the aide address. The MOD then spoke with the resident, who concurred with the information provided by the family member. The MOD followed up with Resident #47 at 1:40 PM, at which time incontinence care had still not been provided. The section of the form titled, Summary of Investigation indicated only that the resident was provided care. The Summary of Findings indicated staff were not communicating with the resident well. The Summary of Actions Taken indicated staff were educated. The form indicated the grievance was resolved on 08/31/2025; however, the section titled, Resolved Note was blank, and there was no documentation to indicate any follow-up investigation or that the efforts to investigate and resolve the grievance were communicated to RR #25 or Resident #47.</p> <p>During an interview on 10/16/2025 at 10:20 AM, Resident #47 stated they had filed a grievance, with the assistance of a representative, after staff did not provide incontinence care. Per Resident #47, two staff members were needed to assist with toileting, and staff informed them that if they provided incontinence care when requested, Resident #47 would not be able to attend church. Resident #47 stated they had to attend church services in a soiled brief. As of the date of this interview, the resident reported they had not received information from administration regarding efforts to resolve the grievance.</p> <p>During an interview on 10/17/2025 at 8:50 AM, RR #25 stated they received a call from Resident #47, who reported attending church in a soiled brief. According to RR #25, staff informed the resident that two staff members and a mechanical lift were required for toileting assistance, and if incontinence care were provided, Resident #47 would not be able to attend church. RR #25 expressed concern that Resident #47 attended the service without the resident's brief being changed. RR #25 indicated no one from the facility had followed up with them regarding the grievance and, as of the date of this interview, they were unaware of any actions the facility had taken to respond to or resolve the grievance.</p> <p>On 10/17/2025 at 9:10 AM, Certified Nursing Assistant (CNA) #39 stated she was late for work on 08/31/2025 and that when she arrived for her shift, Resident #47 was already up in a wheelchair. The CNA indicated she believed the resident had been assisted by CNA #40 and CNA #4. Per CNA #39, she was not aware of the resident's grievance until today, when she was asked to provide a statement. She stated administration had not spoken to her about the resident's grievance prior to today.</p> <p>During an interview on 10/17/2025 at 9:19 AM, the Regional Director of Operations (RDO)/Interim Administrator and Unit Manager (UM) #18 stated they were not aware of the 08/31/2025 grievance until today. Per the RDO, grievances should be routed to the appropriate department for follow-up and investigation, and when a resolution was determined, the outcome should be communicated to the individuals who filed the grievance. The RDO and UM #18 stated they were unsure which staff had been educated, as noted on the grievance form regarding RR #25's grievance on behalf of Resident #47. They stated the facility was now contacting staff for statements and acknowledged that statements should have been collected earlier, when staff may have more accurately recalled the events.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/17/2025 at 9:41 AM, Licensed Practical Nurse (LPN) #2 stated she vaguely recalled a concern about staff refusing to provide incontinence care to Resident #47 prior to church services and that this was communicated to her by the Manager on Duty (MOD). LPN #2 stated she had not contacted by administration regarding the grievance.</p> <p>During an interview on 10/17/2025 at 2:43 PM, CNA #40 stated she did not remember the events related to the grievance involving Resident #47. She reported that administration did not contact her until this morning, when she was asked to come in and write a statement.</p> <p>During an interview on 10/07/2025 at 11:03 AM, the Business Office Manager (BOM), who was the MOD on 08/31/2025, stated she received a call from RR #25 regarding Resident #47, who wanted to be changed but was told by staff that the resident would not be able to get back up to attend church. Resident #47 chose not to be changed and attended church soiled. The BOM stated she reported the incident to the resident's nurse, LPN #2. The BOM said it was inappropriate to tell a resident they would not be changed and have them attend church incontinent. The BOM stated the Administrator managed grievances.</p> <p>During an interview on 10/17/2025 at 3:00 PM, the Interim Director of Nursing (DON) stated that grievances or concerns should be thoroughly investigated, with statements obtained to ensure an accurate summary of action. The DON acknowledged that neither Resident #47 nor RR #25 were informed of the efforts to resolve the grievance and that this did not align with the facility's grievance policy.</p> <p>During an interview on 10/17/2025 at 3:15 PM, the Interim Administrator stated that the grievance process was not followed for Resident #47. She stated after reviewing the grievance, a resolution should be made and communicated to the resident and their representative, which was not done in the case regarding Resident #47. The Administrator stated the expectation was that staff adhere to the facility's grievance and complaint policies and procedures.</p> <p>2. Review of grievance forms and Resident Council Meeting Minutes revealed repeated concerns with call light response times from January 2025 through September 2025, as follows:</p> <p>- A facility Grievance Summaries form dated 01/19/2025 indicated Resident #5's family member submitted a grievance. According to the form, Resident #5 turned on their call light at 3:00 AM because they needed to be cleaned after a bowel movement. At 3:30 PM, they contacted their family because they still had not received care. The family member indicated the care still had not been provided when they visited the facility that morning at 9:30 AM and that the resident finally received care at 10:00 AM. The form indicated multiple interviews were completed with staff on all shifts regarding the resident's concern, and staff reported that after they have provided care and have left the room, the resident would immediately press the call bell again and that the resident's family member was verbally abusive to staff. The actions taken were to meet with the resident and family member to discuss the concerns and report the findings and that both parties agreed to work together for the duration of the resident's stay. The form did not reference whether the facility determined if there had been an actual delay in responding to the call light and meeting the resident's needs.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- A facility Grievance Summaries form dated 02/09/2025 indicated a non-sampled resident's family member reported that the resident had to wait a long time to receive care because everyone was at lunch. The form indicated the aides on Station 2 stated they did not all go to lunch at the same time. The Summary of Findings indicated, Interviewed the nursing staff who reports that they stagger lunch breaks. The facility's action was to advise staff on importance of being seen and available for residents' needs. There was no documentation of efforts to determine if there was a delay in responding to the resident's needs. There was no documentation of follow-up with the resident or their family member as to the facility's efforts to resolve the grievance; however, the form indicated the grievance was resolved on 02/17/2025.</p> <p>- A facility Grievance Summaries form dated 03/11/2025 indicated Resident #35's family member reported that the resident was concerned their call bell was being ignored at times. The Summary of Investigation indicated, Follow up with patient and staff and that it was discussed that there may be times when the Geriatric Nurse Aides (GNAs) were with another resident and that they are not ignoring the resident. The form indicated all parties were satisfied with the follow-up. The form indicated the grievance was resolved 03/24/2025. The form did not specify whether the facility investigated the staff's call bell response times to determine if there were delays. The sections for Summary of Findings and Summary of Actions Taken indicated, See above, which referred the reader to the information in the Summary of Investigation section of the form.</p> <p>During an interview on 10/17/2025 at 1:13 PM, Resident #35 stated they recalled their grievance regarding call light response times and indicated they did not feel the issue had been resolved. The resident indicated they still had to wait an hour for their needs to be met about four or five times a month. The resident's call light was on at the time of this interview, and the resident stated they had been waiting approximately 15 minutes for it to be answered.</p> <p>- A facility Grievance Summaries form dated 03/19/2025 indicated Resident #12's family member reported that the resident often called the family member around 9:00 PM to report that the resident's call bell was going unanswered for an extended period of time. The resident reported to the family member that they often sat in their urine and feces for hours. The Summary of Investigation indicated nursing staff interviewed the resident and staff members involved. The Summary of Findings indicated that staff reported there were times when they were providing care to other residents that it may take longer to answer a call bell. Staff denied that it did not take hours to respond to the resident's call bell. The Summary of Actions Taken indicated nursing staff provided counseling and advice to the appropriate staff and advised the resident of the steps taken.</p> <p>- A facility Grievance Summaries form dated 05/25/2025 revealed a non-sampled resident reported they had to wait over an hour to receive incontinence care and that this was a regular issue. The Summary of Investigation indicated, Report of call bell response times. The form did not specify how the facility investigated the resident's concern. The Summary of Findings indicated that at times, there were occurrences when staff may take longer when they were attending other residents. The Summary of Actions Taken indicated the unit supervisor met with staff regarding response times and asked staff to let the resident know if there was going to be a delay due to attending other residents. The grievance was dated as resolved 06/30/2025 (over one month after the grievance was filed), and there was no documentation of any follow-up with the resident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Civic Avenue Salisbury, MD 21804	
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- A facility Grievance Summaries form dated 08/07/2025 indicated a non-sampled resident reported a concern that there was a consistent lack of timely response to requests for assistance to the bathroom for the past 14 nights. The resident requested immediate corrective action to ensure overnight calls for bathroom assistance were responded to promptly and consistently moving forward. The Summary of Investigation reiterated the resident's concerns and did not specify what the facility did to investigate them. The Summary of Findings only indicated, Refer to above. The Summary of Actions Taken indicated nursing supervisors provided education and mentoring for the nursing staff and a care plan (meeting) was held with the resident, nursing, and social services.</p> <p>During an interview on 10/17/2025 at 1:21 PM, the Regional Director of Operations (RDO) stated there was no staff education/training he could find regarding actions taken to resolve the 08/07/2025 grievance.</p> <p>- A facility Grievance Summaries, dated as reported 08/14/2025 indicated the incident date was 08/13/2025 and that a non-sampled resident reported that they had two episodes of shortness of breath and rang the call bell incessantly, but staff could not be reached. The Summary of Investigation reiterated the resident's concern and did not include any documentation of how the facility investigated the concern. The Summary of Findings indicated only, Refer to above. The Summary of Actions Taken indicated respiratory staff saw the resident and addressed their concerns. The form indicated the respiratory staff checked on the resident multiple times daily and that the nursing supervisor spoke to the resident and family to their satisfaction.</p> <p>Review of Resident Council Minutes dated from 02/2025 through 09/2025 revealed residents complained of delays in call light response times as follows:</p> <p>- Resident Council Minutes dated 02/06/2025 indicated under Old Concerns that residents reported having to wait for long periods before call bells were answered. The response column indicated call bell response times were being actively monitored and audited to ensure timely response.</p> <p>- Resident Council Minutes dated 03/11/2025 indicated under New Concerns that residents reported that nursing staff were on their cell phones sitting behind the nurses' station and not answering call bells. The response column indicated staff should not be on cell phones and that education was provided.</p> <p>- Resident Council Minutes dated 04/04/2025 indicated under New Concerns that residents reported staff were still turning off call bells before the residents' needs were met. The response column indicated call bells were to be left on until needs were met and that the unit managers and nursing supervisors would address this with staff and monitor.</p> <p>- Resident Council Minutes dated 05/01/2025 included the concern related to call bells from the 04/04/2025 council meeting were addressed under Old Concerns. The minutes did not indicate whether the concern had been resolved or had improved.</p> <p>- Resident Council Minutes dated 07/04/2025 indicated, Still an issue with turning off lights [call bells] until the need is meant [met]. No response was documented under the response column.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Resident Council Minutes dated 08/01/2025 indicated in the New Concerns column that residents requested a meeting with staff to discuss the practice of turning off call bells without the residents' need being met. The response column indicated, Staff have been educated and that resident should advise in the moment when staff turned off call bells without advising.</p> <p>- Resident Council Minutes dated 09/05/2025 did not reference any follow-up discussion of the call bell concern submitted by the residents during the August 2025 meeting.</p> <p>During an observation on 10/08/2025 at 11:40 AM, the call light for 203B was noted to be on and flashing.</p> <p>- During an interview on 10/08/2025 at 11:55 AM, Licensed Practical Nurse (LPN) #12 stated a flashing call light meant it had been on for some time, but she did not know how long it needed to be on in order for the light to change from solid to flashing. The light for 203B was still on at the time of this interview.</p> <p>- During an observation on 10/08/2025 at 12:00 PM, the call light for 203B was on but was solid instead of flashing. During an interview with the resident, they stated their call light had been answered but the need had not been met. Based on continued observations, staff did not provide the resident's requested need until 12:05 PM.</p> <p>During an observation on 10/08/2025 at 12:00 PM, Resident #35's call light was noted to be on and flashing. An interview with Resident #35 at this time revealed the resident had requested acetaminophen and had been waiting since 11:00 AM.</p> <p>During an interview on 10/08/2025 at 12:05 PM, Geriatric Nurse Aide (GNA) #24 stated a call light should not be turned off until the resident's need was met.</p> <p>During a phone interview on 10/15/2025 at 3:11 PM, GNA #50 stated that staff tried to answer call lights as fast as they could, but sometimes there were three or four lights going off simultaneously. She indicated the GNAs tried to work as best as they could, but things would be faster or quicker if they had more staffing.</p> <p>During an interview on 10/17/2025 at 1:21 PM, the Regional Director of Operations (RDO) stated that call lights should be answered timely and as soon as possible. There was no specific threshold for the number of minutes the facility targeted. If there was a pattern in the grievances, the facility should be taking a different approach based on what was working and not working. He stated it would be hard to answer what the facility was doing to address grievances because he was not the Administrator. He was not sure if the concerns referenced in the grievances had been addressed in the Quality Assurance and Performance Improvement (QAPI) committee but stated he would search for any related Performance Improvement Plan (PIP). No documentation regarding QAPI was provided by the end of the survey.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/17/2025 at 1:49 PM, the Regional Nurse Consultant (RNC) stated the call light should be answered as soon as possible. She did not know what the threshold was for call lights changing from solid to flashing. She also did not indicate whether there was a certain timeframe targeted by the facility in terms of how quickly call lights should be answered. She stated she could not speak to the grievances, as she was not the Director of Nursing (DON) but stated the facility's grievance policy should be followed.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, interview, and facility policy review, the facility failed to protect Resident #16's right to be free from physical abuse by another resident (Resident #49). This affected 1 (Resident #16) of 23 sampled residents reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 04/2021, revealed, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. A facility policy titled, Identifying Types of Abuse, revised 09/2022, revealed, 1. Abuse of any kind against residents is strictly prohibited. 2. Abuse prevention includes recognizing and understanding the definitions and types of abuse that can occur. The policy specified, 4. 'Abuse' is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The section of the policy titled, Physical Abuse revealed, 1. Physical abuse includes, but is not limited to hitting, slapping, biting, punching or kicking, and 4. Examples of injuries that could indicate physical abuse include, but are not limited to: d. bite marks, scratches, skin tears, and lacerations with or without bleeding. An admission Record revealed the facility admitted Resident #16 on 05/28/2023. According to the admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, muscle wasting and atrophy, muscle weakness, Alzheimer's disease, and generalized anxiety disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/01/2025, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident #16's Care Plan Report included a focus area, initiated 05/11/2025, that indicated the resident had a psychosocial well-being problem related to a negative interaction with another resident. An admission Record revealed the facility admitted Resident #49 on 03/13/2025. According to the admission Record, the resident had a medical history that included diagnoses of vascular dementia, insomnia, and age-related physical debility. A quarterly MDS, with an ARD of 08/01/2025, revealed Resident #49 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Resident #49's Care Plan Report included a focus area, initiated 03/13/2025, that indicated the resident used antipsychotic medication related to behavior management. Another focus area, initiated 05/04/2025, indicated the resident had the potential to demonstrate physical behaviors related to dementia, history of harm to others, and poor impulse control. A focus area, initiated 05/11/2025, indicated the resident had the potential to demonstrate verbally abusive behaviors related to dementia and poor impulse control. Resident #49's Progress Notes revealed a eINTERACT SBAR [Situation, Background, Assessment, Recommendation] Summary for Providers note, dated 05/10/2025 at 10:47 PM, that indicated a change in condition evaluation was completed due to behavioral symptoms, including increased confusion and physical aggression. The note indicated staff observed Resident #49 on the bed of another resident fighting over a pillow. The note indicated Resident #49 was agitated and aggressive towards the other resident, who now has a skin tear. Resident #49's Progress Notes revealed a Health Status Note, dated 05/11/2025 at 7:35 AM, that indicated Resident #49 was observed on their roommate's side of the room arguing with their roommate over a pillow on 05/10/2025. Review of census information for Resident #16 and Resident #49 revealed they were roommates at the time of the incident on 05/10/2025. Resident #16's Progress Notes revealed a eINTERACT SBAR Summary for Providers note, dated 05/10/2025 at 10:28 PM, that indicated the resident had a change in condition related to a skin wound. The note indicated Resident #16 was observed with another resident in Resident #16's bed, the residents were fighting over Resident #16's pillow, and Resident #16 was observed with a wound on their right forearm. During an interview on 10/15/2025 at 3:28 PM, Licensed Practical Nurse (LPN) #62 stated she observed the altercation between Resident #16 and Resident #49 (on 05/10/2025). She stated Resident #49 was arguing with Resident #16 about the pillow, and she observed Resident #49 with his fingernails in Resident #16's arm. LPN #62 stated she attempted to separate the residents and was eventually able to coach Resident #49 out of the room.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on record review, interview, and facility policy review, the facility failed to implement its abuse prohibition and prevention policies for 9 (Residents #6, #11, #14, #18, #22, #24, #30, #34, and #35) of 21 residents reviewed for abuse. Specifically, the facility failed to report allegations of abuse/neglect/injuries of unknown origin to local law enforcement and/or the ombudsman and failed to follow the facility's policy related to conducting and documenting thorough investigations of allegations. Findings included: A facility policy titled, Abuse, Neglect, Exploitation or Misappropriation &amp; Reporting and Investigating, dated 09/2022, indicated, 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility's medical director. The policy also indicated, 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly.</p> <p>1. An admission Record revealed the facility admitted Resident #6 on 08/09/2024. According to the admission Record, the resident had diagnoses that included muscle wasting and atrophy, difficulty in walking, major depressive disorder, and generalized anxiety disorder.</p> <p>Resident #6's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/16/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 9, which indicated the resident had moderate cognitive impairment.</p> <p>Resident #6's quarterly MDS, with an ARD of 02/15/2025, revealed the resident had a BIMS of 14, which indicated the resident was cognitively intact.</p> <p>Resident #6's Care Plan revealed a problem statement, initiated 02/05/2025, that indicated the resident had a psychosocial well-being problem related to anxiety and depression and allegations of physical abuse from staff.</p> <p>A report titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form, dated 02/03/2025, revealed that Resident #6 alleged that a Geriatric Nurse Aide (GNA) was rough during care. The resident was uncertain of the time but stated it was during the day this past Friday [01/31/2025].</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A report titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report Form, dated 02/07/2025, revealed that Resident #6 stated that the nursing aide was rough with resident's care. The report also indicated that the GNA stated there were no issues with resident care. The report did not indicate if any other staff were interviewed during the investigation. There was only one statement from GNA #30 included in the report. Resident #6's statement was not included in the report.</p> <p>An undated statement from GNA #30 revealed that the aide worked with Resident #6 on 01/31/2025 from 7:00 AM to 9:00 PM. The statement indicated that two other staff members were present while she provided care, GNA #34 and GNA #35.</p> <p>During an interview on 10/08/2025 at 8:42 AM, the Social Services Director (SSD) stated that the Administrator and the Director of Nursing (DON) were responsible for investigating abuse. There were times when the SSD interviewed residents, but that was not the case for every resident. If she did perform the interview, the statement would go to the DON's investigation folder.</p> <p>During an interview on 10/15/2025 at 9:52 AM, the Regional Director of Operations (RDO) stated a thorough investigation of abuse looked at several things. The Administration interviewed the residents involved, if interviewable, as well as staff on the unit to get an understanding of what happened during the alleged time frame. The RDO confirmed there was no statement from the resident who made the allegation or from GNA #34 and GNA #35. Furthermore, he stated if staff members were named in the investigation, they should be interviewed as well. The resident who made the allegation should also have a statement. The RDO said those interviews were part of their policy and protocol. The Regional Nurse Consultant was also present during the interview, and she confirmed the expectations communicated by the RDO.</p> <p>2. An admission Record revealed the facility admitted Resident #14 on 02/18/2025. According to the admission Record, the resident had diagnoses that included muscle wasting and atrophy, generalized anxiety disorder, morbid obesity, and difficulty in walking.</p> <p>Resident #14's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/19/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.</p> <p>Resident #14's Care Plan revealed a problem statement, initiated 02/18/2025, that indicated the resident had an Activities of Daily Living (ADL) performance deficit related to weakness.</p> <p>A report titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form, dated 02/22/2025, revealed that Resident #14 alleged that a Geriatric Nursing Assistant (GNA) slung [their] arm and threw their cell phone. The report referenced a specific staff member, but that staff member was not identified.</p> <p>A report titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report Form, dated 02/07/2025, revealed that Resident #14 stated that the nursing aide was rough with resident's care. The report also indicated that the GNA stated there were no issues with resident care. The report did not indicate if any other staff were interviewed during the investigation. There were no statements from any staff, witnesses, or even Resident #14 included in the report.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/07/2025 at 10:42 AM, the Director of Nursing (DON) stated she could not find any statements from the investigation.</p> <p>During an interview on 10/15/2025 at 9:52 AM, the RDO stated a thorough investigation of abuse looked at several things. The Administration interviewed the residents involved, if interviewable, as well as staff on the unit to get an understanding of what happened during the alleged time frame. The RDO confirmed there were no statements in the report file from Resident #14 or any staff members. Specifically, he stated that they were confident everything from the facility investigation had been submitted to the survey team. Furthermore, he stated if staff members were named in the investigation, they should be interviewed as well. The resident who made the allegation should also have a statement. The RDO said those interviews were part of their policy and protocol. The Regional Nurse Consultant was also present during the interview, and she confirmed the expectations communicated by the RDO.</p> <p>3. An admission Record revealed the facility admitted Resident #11 on 12/12/2024. According to the admission Record, the resident had diagnoses that included chronic obstructive pulmonary disease, congestive heart failure, generalized anxiety disorder, major depressive disorder, and chronic pain syndrome.</p> <p>Resident #11's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/22/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.</p> <p>Resident #11's Care Plan revealed a problem statement, initiated 07/26/2025, that indicated the resident had a behavior problem, becoming aggressive and accusatory with staff when frustrated.</p> <p>A report titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form, dated 07/26/2025, revealed that Resident #11 alleged that the housekeeper pushed them. The incident occurred at approximately 11:30 AM.</p> <p>A report titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report Form, dated 07/28/2025, included a statement from Certified Medication Aide (CMA) #26, who observed the incident between Resident #11 and Housekeeper #28. There were no statements, however, from Resident #11 or Housekeeper #28 included in the report.</p> <p>An Accident/Incident Witness Interview Tool, dated 07/26/2025 at 11:25 AM, revealed that CMA #26 observed Resident #11 follow Housekeeper #28 from one resident room to another. The resident insisted that the housekeeper go back to clean their room more. Housekeeper #28 explained to Resident #11 that she had already cleaned the room. The resident attempted to make themselves fall by throwing themselves into the wall. The CMA assisted the resident to stand, and Resident #11 insisted that Housekeeper #28 had pushed them.</p> <p>During an interview on 10/10/2025 at 4:18 PM, the RDO stated there was no evidence of ombudsman notification or police notification for Resident #11's allegation.</p> <p>During an interview on 10/11/2025 at 1:03 PM, the RDO stated they did not have a skin audit for Resident #11 on the date of the incident (07/26/2025).</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/11/2025 at 2:02 PM, the DON stated she recalled speaking to a few staff members but did not recall if there was a statement from Housekeeper #28 or Resident #11. She indicated the facility did not interview other residents on the hallway about Housekeeper #28, since CMA #26 was able to witness and unsubstantiate the abuse allegation in the moment.</p> <p>During an interview on 10/11/2025 at 10:35 AM, the Ombudsman stated the incident involving Resident #11 and Housekeeper #28 was not reported on 07/26/2025. Specifically, it was reported to the Ombudsman on 10/10/2025.</p> <p>During an interview on 10/15/2025 at 9:52 AM, the RDO stated a thorough investigation of abuse looked at several things. The Administration interviewed the residents involved, if interviewable, as well as staff on the unit to get an understanding of what happened during the alleged time frame. The RDO confirmed there were no statements in the report file from Resident #11 or Housekeeper #28. Specifically, he stated that they were confident everything from the facility investigation had been turned over. The resident who made the allegation should also have a statement. The RDO said those interviews were part of their policy and protocol. The Regional Nurse Consultant was also present during the expectations interview, and she confirmed the expectations communicated by the RDO. She also added that it was part of the facility process to notify the Ombudsman of abuse allegations.</p> <p>4. An admission Record revealed the facility admitted Resident #30 on 02/20/2023. According to the admission Record, the resident had a medical history that included diagnoses of aphagia following cerebral infarction, dysphagia, oral phase, and vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>A Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form revealed an allegation of neglect was filed by the facility on 01/29/2025 at 2:30 PM by the facility's Director of Nursing (DON). The Report Form revealed an allegation was made by a family member of Resident #30 involving neglect of care and services on 01/29/2025 at 1:30 PM. The Report Form revealed a notification to law enforcement was not made.</p> <p>During an interview on 10/15/2025 at 10:50 AM, the Interim DON (Int. DON) stated allegations of neglect should be reported to law enforcement, and she would expect staff to follow the facility policy as far as reporting was concerned.</p> <p>5. Review of Initial Reports revealed the following:</p> <ul style="list-style-type: none"> <li>- An Initial Report dated 06/04/2025 at 3:40 PM for Resident #22 indicated an allegation of verbal abuse was not reported to other agencies.</li> <li>- An Initial Report dated 04/03/2025 at 11:15 AM for Resident #24 indicated an allegation of an injury of unknown origin was not reported to other agencies.</li> </ul> <p>An Initial Report dated 02/17/2025 at 3:18 PM for Resident #34 indicated an allegation of verbal abuse was not reported to other agencies.</p> <p>An Initial Report dated 03/12/2025 at 10:30 AM for Resident #35 indicated an allegation of verbal abuse was not reported to other agencies.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Civic Avenue Salisbury, MD 21804	
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/08/2025 at 9:05 AM, the Regional Director of Operations/Interim Administrator (RDO) stated he expected staff to follow their policy and report all allegations to all agencies as required.</p> <p>During an interview on 10/16/2025 at 3:04 PM, the Regional Nurse Consultant/Interim Director of Nursing (Inter. DON) stated she expected the staff to report allegations to the police and the ombudsman.</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure four (Resident #41, Resident #11, Resident #22, and Resident #33) of 23 residents reviewed for abuse were reported/timely reported to the Administrator and State Survey Agency (SSA) and failed to ensure the results of investigations were submitted to the SSA/submitted within five working days of the incident for four (Resident #11, #2, 22, and 34 of 23 reviewed for abuse. Specifically, the failed to report/timely report the following: 1. Resident #41 reported Registered Nurse (RN) #20 physically abused the resident on 09/13/2025. Staff reported the incident to the Director of Nursing (DON); however, the DON failed to report the allegation to the SSA.2. Resident #11 reported that Housekeeper #28 pushed them. The facility failed to report the allegation to the SSA no later than two hours after the allegation was made and failed to report the results of the investigation to the SSA within five working days. 3. Resident #33 reported that Resident #22 attempted to touch Resident #33's genitals, and reported that after the resident reported the incident, Resident #22 and their significant other Resident #40, retaliated against the resident. Staff reported the allegations to the DON; however, the facility failed to report the allegations to the SSA.4. The facility failed to submit the results of an investigation regarding an allegation regarding Resident #2's injury of unknown origin.5. The facility failed to submit an abuse allegation regarding Resident #22 to the SSA no later than two hours after the allegation was made and failed to report the results of an abuse allegation within five working days.6. The facility failed to submit the results of an abuse allegation regarding Resident 34 within five working days of the incident. The failure to address residents' abuse allegations had the likelihood for further potential abuse and for physical and/or psychosocial harm to residents. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy was related to State Operations Manual, Appendix PP, F609, Reporting of Alleged Violations, at a scope and severity of K.The IJ began on 09/13/2025 when the facility failed to report an allegation of physical abuse.The survey team notified the DON and the Regional Director of Operations (RDO) of the IJ and provided the IJ template on 10/11/2025 at 6:26 PM. A removal plan was requested. The facility's removal plan was accepted by the state survey agency on 10/12/2025 at 1:57 AM. The IJ was removed on 10/12/2025, after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F609 remained at a lower scope and severity of E, a pattern, no actual harm with the potential for more than minimal harm. Findings included: A facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 09/2022, revealed, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. The policy revealed, 3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury. The policy also indicated, 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. The policy for Follow-Up Report, also revealed, Within five (5) days of the incident, the administrator will provide a follow-up investigation report.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. Resident #41's demographic sheet revealed the resident had a medical history that included diagnoses of muscle wasting and atrophy, atherosclerotic heart disease, essential hypertension, chronic obstructive pulmonary disease (COPD), generalized anxiety, and major depressive disorder.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/07/2025, revealed Resident #41's most recent admission to the facility was on 07/01/2025. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS also indicated the resident required supervision or touching assistance for bed-to-chair transfer.</p> <p>Resident #41's Care Plan Report, included a focus area, initiated 05/24/2025, that indicated the resident had sustained falls and continued to be at risk for falls related to deconditioning, weakness, and gait/balance problems. Interventions directed staff to provide hands-on assistance for moving from place to place (initiated 06/16/2025).</p> <p>During an interview on 10/10/2025 at 2:50 PM, Resident #41 stated that RN #20 had grabbed their head, squeezed their arm really hard, and hurt the resident. The resident stated it really made them mad. Resident #41 stated they told Unit Manager (UM) #18 that the nurse abused them. The resident stated they felt like UM #18 did not take the allegation seriously; subsequently, the resident told the UM to drop it and the UM said okay.</p> <p>The facility's self-reported incident list, for the timeframe from 02/03/2025 through 09/21/2025, indicated no report was made to the SSA regarding Resident #41's abuse allegation.</p> <p>During an interview on 10/08/2025 at 3:51 PM, Certified Medication Assistant (CMA) #11 stated Resident #41 reported that RN #20 grabbed them by the top of their head to get the resident off the floor after the resident fell out of their wheelchair on Saturday, 09/13/2025. Per CMA #11, the resident reported that RN #20 hurt them, and the resident was very irate about the situation. CMA #11 stated she notified Licensed Practical Nurse (LPN) #22 of the situation.</p> <p>During an interview on 10/09/2025 at 11:03 AM, Geriatric Nurse Aide (GNA) #21 stated that Resident #41 had fallen on the floor while the GNA was in another resident's room. She stated the door was closed but she could hear RN #20 yelling at the resident, telling the resident to Get up! Just get up! in a forceful manner. Per GNA #21, once the door was opened, Resident #41 stated that RN #20 pinned them down on the floor with his hand on top of the resident's head, roughed the resident up, and the resident could not get off the floor. GNA #21 stated that after the incident, Resident #41 told her that RN #20 brought the resident snacks, assisted the resident to and from the smoking area, and was trying to butter up the resident. GNA #21 stated she also reported the incident to LPN #22, the supervisor on duty the night of 09/13/2025.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/10/2025 at 11:39 AM, RN #20 stated the nurses asked him to assist with a resident who had fallen. RN #20 stated Resident #41 was sitting on the floor beside their bed in their room and the door was open while he was in the resident's room. He stated he performed a head-to-toe assessment of the resident, which included assessing the resident's head and palpating their arms to make sure there was no injury. RN #20 stated the resident had no concerns or complaints during the assessment and there were no injuries. According to RN #20, he did not recall documenting the assessment. RN #20 stated he did not remember who helped him assist the resident off the floor but stated it would have taken at least two people because the resident was not capable of getting up on their own. He stated the resident did not voice any complaints while moving them. Per RN #20, he interacted with Resident #41 after the fall and took the resident to smoke and to the snack machines and did not remember anything else about the event. RN #20 stated he wrote a witness statement and gave it to LPN #22.</p> <p>During an interview on 10/10/2025 at 2:30 PM, LPN #22, who worked as the weekend supervisor, stated that GNA #21 called to tell her that she heard RN #20 yelling at Resident #41. LPN #22 stated she spoke with Resident #41 and got the resident's written statement. She stated that when the resident fell, the resident was upset. LPN #22 stated she was not sure whether RN #20 made the resident upset; however, when she asked the resident what happened, whether the resident was hurt, and if the resident felt like RN #20 did something to them, the resident stated no. LPN #22 stated that she later saw RN #20 take the resident out to the smoking area and she asked the resident again if everything was okay, and the resident stated they were fine and did not think RN #20 meant to hurt them. She stated that when she spoke with LPN #38, the LPN stated that the resident was upset and the LPN told RN #20 to give the resident some space. LPN #22 stated she obtained witness statements from GNA #21, RN #20, and LPN #38. She stated she also notified the DON and the Administrator of the details of the fall/incident. Per LPN #22, the DON stated that she did not think that RN #20 was trying to hurt the resident based on the information she had provided.</p> <p>During an interview on 10/10/2025 at 4:04 PM, UM #18 stated that prior to that day, she had no knowledge of an incident with Resident #41 and RN #20.</p> <p>During an interview on 10/10/2025 at 3:43 PM, the DON stated that she expected staff to report abuse allegations to her or the Administrator. Per the DON, LPN #22 reported that Resident #41 had fallen and that the RN hurt them while getting them up off the floor. During a follow-up interview on 10/11/2025 at 2:09 PM, the DON stated that she was not aware that Resident #41 accused RN #20 of squeezing their head and twisting their arms until 10/09/2025.</p> <p>2. An admission Record revealed the facility admitted Resident #11 on 12/12/2024. According to the admission Record, the resident had a medical history that included diagnoses of atrial fibrillation, malignant neoplasm of the kidney and bladder neck, chronic obstructive pulmonary disease, congestive heart failure, generalized anxiety disorder, major depressive disorder, restlessness and agitation, and chronic pain syndrome.</p> <p>Resident #11's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/22/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.</p> <p>Resident #11's Care Plan revealed a focus area, initiated 07/26/2025, that indicated the resident had a behavior problem, becoming aggressive and accusatory with staff when frustrated.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A Facility Reported Incident Initial Report Form, dated 07/26/2025, revealed that Resident #11 alleged that Housekeeper #28 pushed them while in the resident's room at approximately 11:30 AM on 07/26/2025. According to the report, the Administrator submitted the report to the state agency (SA) on 07/26/2025 at 12:31 PM.</p> <p>A Facility Reported Incident Follow-Up Investigation Report Form, dated 07/28/2025, revealed the Director of Nursing (DON) sent the final report on 07/28/2025 at 3:00 PM.</p> <p>An email correspondence dated 10/10/2025 at 4:22 PM with the state agency revealed the initial report regarding Resident #11's allegation was received on 07/26/2025 at 2:36 PM, which was over two hours after the allegation was made. Furthermore, the email correspondence revealed no evidence that a five-day report was submitted to the SA.</p> <p>During an interview on 10/09/2025 at 5:07 PM, Regional Director of Operations (RDO) stated he had never been asked to show confirmation that they had submitted the incident reports to show that they submitted them timely. He said he thought they just took their word that the time that was documented on the reports was when the report was sent in and completed. He said now he understood that without that documentation they could have just put any date/time on the report, and it would not be accurate. He stated that he had no additional documents for any investigations to confirm when the State Agency was notified. Additionally, he expected staff to report any allegation to their supervisor immediately.</p> <p>During an interview on 10/16/2025 at 3:04 PM, Interim (Inter.) DON stated she expected the staff to report to the DON/Administrator immediately because any allegation of abuse had to be reported within two hours.</p> <p>3. An admission Record revealed the facility admitted Resident #33 on 09/15/2020. According to the admission Record, Resident #33 had a medical history that included diagnoses of muscular dystrophy, unspecified heart failure, and generalized muscle weakness.</p> <p>An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/2024, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>A quarterly MDS, with an ARD of 07/03/2025, revealed Resident #33 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS revealed the resident was independent with a motorized wheelchair.</p> <p>Resident #33's Care Plan Report included a focus area initiated 10/03/2024, that indicated Resident #33 was independent in fulfilling their leisure time and had a general willingness to participate in group programs. Interventions directed staff to check in with Resident #33 often to ensure their contentment items provided for self-directed independent leisure (initiated 10/03/2024), and indicated the resident enjoyed various group programs and socializing with other residents/staff (initiated 10/03/2024).</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An admission Record revealed the facility admitted Resident #22 on 10/17/2025. According to the admission Record, Resident #22 had a medical history that included diagnoses of demyelinating disease of the central nervous system, other intervertebral disc degeneration, fibromyalgia, ataxia, bipolar disorder, muscular dystrophy, unspecified heart failure, and generalized muscle weakness</p> <p>A quarterly MDS, with an ARD of 07/26/2025, revealed Resident #22 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS revealed the resident did not exhibit any behavioral symptoms during the assessment look-back period. The MDS revealed Resident #22 was also independent with a motorized wheelchair.</p> <p>Resident #22's Care Plan Report included a focus area dated 07/17/2025 that indicated the resident smoked and was able to smoke independently.</p> <p>A Social Service Assessment, dated 07/09/2025, revealed Resident #33 reported they had not any event that was unusually or especially frightening, horrible, or traumatic.</p> <p>Observation of and interview with Resident #33 on 10/08/2025 at 2:27 PM revealed they were in their room sitting upright in bed. Resident #33 was willing to discuss the details of the incident but was noted to have changes in voice quality during retelling. During an interview, Resident #33 stated that Resident #22 had been acting differently that day (08/24/2025) and Resident #33 believed that Resident #22 was intoxicated with an unknown substance. Resident #33 stated they were outside in the gazebo area and the resident was assisting Resident #22 with lighting their cigarette when Resident #22 started asking for some [vulgar slang term for a body part] Resident #33 stated they told Resident #22 to chill, and Resident #22 reached over and attempted to grab Resident #33's genital area. Resident #33 stated they blocked Resident #22's hands and then attempted to show them the ring worn on their left hand fourth finger. Per Resident #33, Resident #22 then grabbed Resident #33's left hand and attempted to open it and due to Resident #33's medical condition, they had to utilize their right hand to remove Resident #22's hands. At that time, Resident #33 left the gazebo and went back to their room. Resident #33 stated they limited their activity in the facility to prevent contact with Resident #22 and Resident #22's significant other, Resident #40. Resident #33 stated they felt like R#22's significant other had been watching them. The resident stated that on one occasion Resident #33 was waiting for a family member in the main lobby and Resident #22 and Resident #40 stared at the resident, making them feel uncomfortable and the resident elected to return to their room to wait for their family. Resident #33 stated this incident had triggered memories of childhood sexual molestation which had also led to their self-imposed isolation to their room. Resident #33 stated they had told everyone about the incident, but nothing had been done.</p> <p>During an interview on 10/08/2025 at 3:10 PM, Resident #22 stated that they had made a gesture of a male performing sexual self-gratification, and Resident #33 reported them for sexual harassment. Resident #22 denied having touched Resident #33 but reported they were unable to recall what was said during the incident on 08/24/2025.</p> <p>During an interview on 10/09/2025 at 11:53 AM, Resident #40 stated that they were present when the alleged incident occurred in the gazabo on 08/24/2025. Resident #40 stated that Resident #33 made a hand gesture of a male sexually self-pleasuring themselves towards Resident #22 and Resident #40. Resident #40 stated that Resident #22 repeated the hand gesture, and that offended Resident #33. Resident #40 stated they believed the allegation was made due to Resident #33 being jealous of Resident #22 and Resident #40's relationship status.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/09/2025 at 10:02 AM, Geriatric Nurse Aide (GNA) #27 revealed she did not know exactly what happened, but that it had to be something pretty drastic for Resident #33 and Resident #22 to stop interacting. She reported that since that time, Resident #33 did not seem to want to get out of bed.</p> <p>During an interview on 10/09/2025 at 10:45 AM, GNA #24 stated that Resident #33 and Resident #22 were not friends anymore, and Resident #33 was no longer visiting the 200 and 300 Units.</p> <p>During an interview on 10/14/2025 at 2:16 PM, Licensed Practical Nurse (LPN) #15 stated that on Sunday, 08/31/2025 at approximately 10:00 PM, Resident #33 activated their call light and asked to speak with her specifically. She stated Resident #33 was crying and visibly upset. Per LPN #15, Resident #33 reported that Resident #22 had previously touched them and on that night, Resident #33 had gone to the lobby to await family and Resident #22 and Resident #40 cursed at the resident. LPN #15 stated she immediately reported the incident to her supervisor, LPN #22, who contacted the DON. LPN #15 stated the DON instructed her to move Resident #33 to another unit. She stated she moved the resident; however, she stated when she returned to work on Monday, Resident #33 was back in their old room. LPN #15 stated that Resident #33 had not been coming out of the resident's room since the incident because the resident was scared. She stated she had noticed the resident coming out more that week.</p> <p>During an interview on 10/16/2025 at 9:05 AM, LPN #22 stated that she had contacted the DON and the Administrator on Sunday (08/31/2025) with the allegation (unable to recall allegation details) and the decision was made to move Resident #33 to the 500 Unit.</p> <p>During an interview on 10/11/2025 at 3:18 PM, Unit Manager (UM) #10 stated Resident #33 told her about the incident several days after the occurrence (unable to recall the exact date). She stated that the resident reported that they were helping Resident #22 to smoke when something sexual was said, but she could not remember the details. UM #10 stated they also recalled something about Resident #33 showing their promise ring and talking about the importance of the item to them. Per UM #10, Resident #33 was worried that Resident #22 and Resident #40 would retaliate against them; however, she stated that she had not seen any retaliation against Resident #33. She stated that she was unable to recall any further details from the report. UM #10 stated she immediately reported the allegation to the DON, and the Mental Health Nurse Practitioner had seen the resident. According to UM #18, there had been no changes in Resident #33's behavior since the incident.</p> <p>During an interview on 10/09/2025 at 11:25 AM, the DON and the RDO revealed that Resident #33 had reported that Resident #22 made a comment about wanting [vulgar slang term for a body part], which made Resident #33 uncomfortable. The DON stated that she was also aware that Resident #33 felt like Resident #40 was watching them and that Resident #33 had elected to keep to themselves and not interact with the residents. Per the DON, they had treated this incident more from a perspective of the loss of friendship as the three residents had been friends prior to the incident. The DON stated they did not feel like it had reached the level of reporting or investigating.</p> <p>On 10/12/2025 at 1:59 AM, a Removal Plan was submitted by the facility and accepted by the State Agency, as follows:</p> <p>Corrective actions which will be accomplished for those residents found to have been affected.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> <li>1. Statements were obtained from involved residents #41, #22 and #33. Resident #11 is no longer in the facility on 10/11/25 by the Nurse manager.</li> <li>2. Resident #41, Resident #22, and Resident #33 were assessed to ensure no injuries, physical or psychological, were present on 10/12/25 by the nurse manager. There were no new findings for residents# 41, #22 and #33.</li> <li>3. RN #20 and Housekeeper #28 have been suspended on 10/11/2025 by Regional Director of Operations.</li> <li>4. The administrator and director of nursing have been suspended on 10/11/25 by Regional Director of Operations.</li> <li>5. Statements were obtained from the accused employees #20 and #28 on 10/11/25 by Regional Nurse.</li> <li>6. Social Services has met with involved residents #41, #22 and #33 to address any psychosocial concerns on 10/12/25. Resident #11 is no longer residing in the facility.</li> <li>7. Residents #41 (allegation of physical abuse) and #33 (allegation of sexual abuse) responsible parties were made aware of the allegations by Nurse manager. Resident #11 is no longer in the facility. Education provided for timely abuse reporting based on CMS regulation.</li> <li>8. Medical Directors were made aware of the allegations of physical and sexual abuse on 10/11/25.</li> <li>9. Police were notified of the allegations of physical and sexual abuse on 10/09/25 and 10/10/25. Maryland Department of Health was notified of the allegations of physical and sexual abuse on 10/11/25.</li> <li>10. Medical Directors were notified of the allegations of physical and sexual abuse for residents #41 and #33 on 10/11/25.</li> <li>11. Ombudsman was notified of the allegations of physical and verbal abuse on 10/12/25.</li> <li>12. Trauma informed evaluations completed for identified residents #41 and #33 on 10/11/25.</li> </ol> <p>Measures that will be put in place and systemic changes that will be made to ensure that the practices do not recur.</p> <p>Current employees will receive education regarding reporting abuse on 10/12/25 by Nurse Manager.</p> <p>Nurse managers and social workers will be educated on abuse reporting on 10/12/25 by Regional Nurse.</p> <p>Newly hired employees and vendors will receive education regarding reporting abuse prior to assuming any assignment by nurse manager.</p> <p>How the corrective actions will be monitored to ensure the practices will not re-occur.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Civic Avenue Salisbury, MD 21804	
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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The results of the interviews will be reported during the monthly Quality Assurance Performance Improvement (QAPI) Meeting for 3 months.</p> <p>The resident interviews will continue until the QAPI Committee has determined that there is substantial compliance. Upon sustained compliance, the QAPI Committee will recommend the reduction or resolution of the audits.</p> <p>AD Hoc held on 10/11/25.</p> <p>The QAPI has been reviewed by the Medical Director on 10/12/25</p> <p>Allegation of Compliance</p> <p>The facility alleges compliance with this plan on 10/12/2025.</p> <p>The immediacy of the IJ was removed on 10/12/25.</p> <p>Onsite Verification of Removal Plan:</p> <p>The IJ was removed on 10/13/2025 after the survey team completed onsite verification that the Removal Plan had been implemented. Noncompliance remained at the lower scope and severity of E. Verification was completed as follows:</p> <ol style="list-style-type: none"> <li>1. Witness statements from Residents #22, #33, and #41 were obtained by the DON.</li> <li>2. Resident #22's weekly skin check assessment dated [DATE] no new skin impairments were identified, and the social services assessment dated [DATE] revealed the facility identified that the resident had a history of past sexual/physical abuse and was currently receiving psychiatric services. Resident #33's weekly skin assessment dated [DATE] revealed no new skin impairments were identified, and a social service assessment dated [DATE] revealed no emotional distress was identified. Resident #41's weekly skin check dated 10/09/2025 revealed no new skin impairments were identified, and a social service assessment dated [DATE] revealed the resident had no verbal indicators or emotional distress/anxiety.</li> <li>3. Registered Nurse (RN) #20's timecard sheet revealed their last date worked was on 09/29/2025 and Housekeeper #28's last date worked was on 10/11/2025.</li> <li>4. Record review revealed the RDO placed the Administrator and DON on administrative leave on 10/11/2025.</li> <li>5. Record review revealed the facility obtained statements from RN #20 and Housekeeper #28 of their witness accounts of the allegations against them.</li> <li>6. Record review revealed social services staff met with Resident #33 on 10/11/2025 and identified the resident as self-isolating and feeling guilty. Record review revealed social services staff met with Resident #41 on 10/11/2025 and identified no verbal indicators or emotional distress/anxiety during assessment.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>7. Record review revealed Resident #33's representative was made aware of the abuse allegation on 10/11/2025 at 9:56 PM, and Resident #41's representative was made aware of the abuse allegations on 10/09/2025 at 3:15 PM.</p> <p>8. Record review revealed the RDO notified the Medical Director of the allegation of physical abuse for Resident #41 and sexual abuse for Resident #33.</p> <p>9. Record review revealed local Law Enforcement was notified of Resident #33's allegation of sexual abuse allegation and Resident #41's allegation of physical abuse allegation on 10/10/2025 and 10/09/2025, respectively.</p> <p>10. Record review revealed the facility notified the SSA of Resident #41's physical abuse allegation on 10/09/2025 and Resident #33's allegation of sexual abuse on 10/09/2025.</p> <p>11. Record review revealed Medical Directors were notified of the allegations of abuse on 10/11/2025.</p> <p>12. Record review revealed the facility notified the Ombudsman of the allegations of abuse Resident #41 and Resident #33 on 10/12/2025.</p> <p>13. Record review revealed Resident #33's trauma assessment completed on 10/11/2025 identified past sexual abuse and Resident #41's trauma assessment completed on 10/11/2025 identified no current trauma concerns.</p> <p>Measures that will be put in place and systemic changes that will be made to ensure that the practices do not recur.</p> <p>Interviews were conducted on 10/13/2025 with current staff onsite and via telephone for verification of abuse education received.</p> <p>Nurse managers and social workers were interviewed on 10/13/2025, onsite for verification of abuse education and training.</p> <p>Newly hired staff and vendors were to be provided abuse training prior to assignment. No newly hired staff or vendors began during the survey.</p> <p>How the corrective actions will be monitored to ensure the practices will not re-occur.</p> <p>The Medical Director on 10/13/2025 stated interviews would be reported during QAPI for the next three months.</p> <p>The Medical Director on 10/13/2025 stated the resident interviews would continue to be reported during QAPI until compliance was met.</p> <p>The Medical Director on 10/13/2025, stated he attended the Ad Hoc meeting on 10/11/2025.</p> <p>The Medical Director on 10/13/2025, stated he reviewed the QAPI.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>4. An admission Record revealed the facility admitted Resident #2 on 06/06/2025. According to the admission Record, Resident #2 had a medical history that included muscle wasting and atrophy, type 2 diabetes mellitus with diabetic chronic kidney disease, compression fracture of the second lumbar vertebra, vascular dementia, and age-related physical debility.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/09/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severely impaired cognition. The MDS also revealed that the resident was dependent on staff for activities of daily living (ADL).</p> <p>Resident #2's Care Plan Report included a focus area, dated 06/09/2025, that indicated the resident had an ADL self-care performance deficit related to deconditioning and pain. Interventions directed staff to conduct a skin inspection daily during care, observing for redness, open areas, scratches, cuts, and bruises and to report abnormal findings (initiated 06/09/2025).</p> <p>A document titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form, revealed that on 06/20/2025 at 5:00 PM, the facility was made aware of discoloration to Resident #2's left upper arm. The facility obtained witness statements and performed head-to-toe assessments of other residents. The conclusion for the discoloration was that Resident #2 had been administered insulin in the area of the noted discoloration. The Report indicated it was submitted to the SSA on 06/20/2025 at 6:50 PM.</p> <p>An email correspondence dated 10/10/2025 at 4:22 PM with the SSA revealed the initial report regarding Resident #2's allegation was received on 06/20/2025 at 6:52 PM and no final report was received.</p> <p>During an interview on 10/11/2025 at 6:24 PM, the DON stated she submitted the facility's five-day report but was unable to provide any type of confirmation.</p> <p>During an interview on 10/11/2025 at 6:24 PM, the RDO revealed they believed there were problems with the way the SSA had them submit final reports, because there was no way to get confirmation that the report was accepted.</p> <p>5. An admission Record indicated the facility admitted Resident #22 on 10/17/2024. According to the admission Record, the resident had a medical history t</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure 4 (Residents #41, #11, #33, and #34) of 23 residents reviewed for abuse had thorough investigations completed. Specifically, the facility failed to conduct thorough investigations regarding the following:1. Resident #41 reported Registered Nurse (RN) #20 physically abused the resident on 09/13/2025. Staff reported the incident to the Director of Nursing (DON); however, the DON failed to conduct a thorough investigation and failed to suspend RN #20 placing Resident #41 and additional residents at risk for abuse.2. Resident #11 reported that Housekeeper #28 pushed them. The facility failed to conduct a skin audit or trauma assessment from Resident #11 and failed to obtain a witness statement from Resident #11 and additional residents.3. Resident #33 reported that Resident #22 attempted to touch Resident #33's genitals, and reported that after the resident reported the incident, Resident #22 and their significant other Resident #40, retaliated against the resident. Staff reported the allegations to the DON; however, the facility did not conduct an investigation. Resident #33 self-isolated in their room after the incident.4. The facility received an email correspondence that Resident #34 made an allegation that staff had verbally abused the resident. The facility failed to thoroughly investigate. The facility failed to obtain written interview statements from staff or residents related to the allegation. This failure to thoroughly investigate residents' allegations of abuse had the likelihood for further potential abuse and/or psychosocial harm to occur to residents. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, F610, Investigate/Prevent/Correct Alleged Violation, at a scope and severity of K. The IJ began on 09/13/2025 when the facility failed to report and investigate an allegation of physical abuse. The survey team notified the DON and the Regional Director of Operations (RDO) of the IJ and provided the IJ template on 10/11/2025 at 6:26 PM. A removal plan was requested. The facility's removal plan was accepted by the state survey agency on 10/12/2025 at 1:57 AM. The IJ was removed on 10/12/2025, after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F610 remained at a lower scope and severity of E, a pattern, no actual harm with the potential for more than minimal harm. Findings included:A facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 09/2022, revealed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The policy continued, 1. All allegations are thoroughly investigated. The administrator initiates investigations. The policy continued, 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Findings included:</p> <p>1. Resident #41's demographic sheet revealed the resident had a medical history that included diagnoses of muscle wasting and atrophy, atherosclerotic heart disease, essential hypertension, chronic obstructive pulmonary disease (COPD), generalized anxiety, and major depressive disorder.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/07/2025, revealed Resident #41's most recent admission to the facility was 07/01/2025. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident required supervision or touching assistance for bed-to-chair transfer.</p> <p>Resident #41's Care Plan Report included a focus area initiated 05/24/2025 that indicated the resident had sustained falls and continued to be at risk for falls related to deconditioning, weakness, and gait/balance problems. Interventions directed staff to provide hands-on assistance to move from place to place (initiated 06/16/2025).</p> <p>The facility's self-reported incident list, for the timeframe from 02/03/2025 through 09/21/2025, indicated no report was made to the SSA regarding Resident #41's abuse allegation.</p> <p>During an interview on 10/10/2025 at 2:50 PM, Resident #41 stated that RN #20 had grabbed their head, squeezed their arm really hard, and hurt the resident. The resident stated it really made them mad. Resident #41 stated they told Unit Manager (UM) #18 that the nurse abused them. The resident stated they felt like UM #18 did not take the allegation seriously; subsequently, the resident told the UM to drop it and the UM said okay.</p> <p>During an interview on 10/08/2025 at 3:51 PM, Certified Medication Assistant (CMA) #11 stated Resident #41 reported that RN #20 grabbed them on the top of their head to get the resident off the floor after the resident fell out of their wheelchair on Saturday, 09/13/2025. Per CMA #11, the resident reported that RN #20 hurt them, and the resident was very irate about the situation. CMA #11 stated she notified Licensed Practical Nurse (LPN) #22 of the situation. CMA #11 stated she was never questioned or interviewed about the event and said RN #20 worked the day after the alleged incident.</p> <p>During an interview on 10/09/2025 at 11:03 AM, Geriatric Nurse Aide (GNA) #21 stated that Resident #41 had fallen on the floor while the GNA was in another resident's room. She stated the door was closed but she could hear RN #20 yelling at the resident, telling the resident they needed to get up in a forceful manner. Per GNA #21, once the door was opened, Resident #41 stated that RN #20 pinned them down on the floor with his hand on top of the resident's head, roughed the resident up, and the resident could not get off the floor. GNA #21 stated that after the incident, Resident #41 told her that RN #20 brought the resident snacks, assisted the resident to and from the smoking area, and was trying to butter up the resident. GNA #21 stated she also reported the incident to LPN #22, the supervisor on duty the night of 09/13/2025.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/10/2025 at 2:30 PM, LPN #22, who worked as the weekend supervisor, stated that GNA #21 called to tell her that she [GNA #21] heard RN #20 yelling at Resident #41. LPN #22 stated she spoke with Resident #41 and got the resident's written statement. She stated that when the resident fell, the resident was upset. LPN #22 stated she was not sure whether RN #20 made the resident upset; however, when she asked the resident what happened, whether the resident was hurt, and if the resident felt like RN #20 did something to them, the resident stated no. LPN #22 stated that she later saw RN #20 take the resident out to the smoking area and she asked the resident again if everything was okay, and the resident stated they were fine and did not think RN #20 meant to hurt them. She stated that when she spoke with LPN #38, the LPN stated that the resident was upset and the LPN told RN #20 to give the resident some space. LPN #22 stated she obtained witness statements from GNA #21, RN #20, and LPN #38. She stated she also notified the DON and the Administrator of the details of the fall/incident. Per LPN #22, the DON stated that she did not think that RN #20 was trying to hurt the resident based on the information she had provided. LPN #22 stated no one reached out to her afterward regarding the information she had gathered.</p> <p>During an interview on 10/10/2025 at 11:39 AM, RN #20 stated the nurses asked him to assist with a resident who had fallen. RN #20 stated Resident #41 was sitting on the floor beside their bed in their room and the door was open while he was in the resident's room. He stated he performed a head-to-toe assessment of the resident, which included assessing the resident's head and palpating their arms to make sure there was no injury. RN #20 stated the resident had no concerns or complaints during the assessment and there were no injuries. According to RN #20, he did not recall documenting the assessment. RN #20 stated he did not remember who helped him assist the resident off the floor but stated it would have taken at least two people because the resident was not capable of getting up on their own. He stated the resident did not voice any complaints while moving them. Per RN #20, he interacted with Resident #41 after the fall and took the resident to smoke and to the snack machines and did not remember anything else about the event. RN #20 stated he wrote a witness statement and gave it to LPN #22.</p> <p>During an interview on 10/10/2025 at 4:04 PM, UM #18 stated that Resident #41 had just informed them, minutes ago, that about two weeks prior RN #20 had squeezed the resident's head and twisted the resident's arm. Per UM #18, prior to that day, she had no knowledge of an incident with Resident #41 and RN #20.</p> <p>During an interview on 10/10/2025 at 3:43 PM, the DON stated that she expected staff to report abuse allegations to her or the Administrator. Per the DON, LPN #22 reported that Resident #41 had fallen and that the RN hurt them while getting them up off the floor. The DON stated that she just found out about the alleged abuse from UM #18, had just reported it to the State Agency, obtained a witness statement from the resident, and notified the police.</p> <p>During a follow-up interview on 10/11/2025 at 2:09 PM, the DON stated that she was not aware that Resident #41 accused RN #20 of squeezing their head and twisting their arms until 10/09/2025. She stated had she known about the allegation from the resident, RN #20 would have been suspended then. The DON she had no witness statements for Resident #41 from 09/13/2025.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/16/2025 at 10:08 AM, the Regional Director of Operations (RDO) stated the Administrator and DON should be involved in the investigation of an allegation of abuse. Per the RDO, the investigation should include interviews of staff and residents, skin assessments, interviews of the individual's assignments, and notification of the appropriate agencies, Physicians, emergency contacts if the individual was not their own representative, and other documentation related to the individual. The RDO stated a folder was comprised of documents with a checklist that ensured the investigation had been completed and was thorough. He stated the checklist listed exactly what to look at and what to have on file for the facility. The RDO said the investigation file was maintained for 10 years. Per the RDO, staff had been trained and were expected to ensure interviews with all parties, skin assessments, notifications to the appropriate agencies, and the checklist had been completed.</p> <p>During an interview on 10/16/2025 at 3:04 PM, the Interim Director of Nursing (Int. DON) stated she expected staff to know that when they were aware of an incident they needed to bring the allegation to the attention of their supervisor, ADON (Assistant Director of Nursing), and DON immediately. She stated the first expectation was to keep the residents safe and to report the allegation. The Int. DON stated that for a complete investigation staff should collect statements and make sure they had all the pieces of the investigation to do a thorough investigation. She stated she expected the DON/Administrator to do a complete investigation. She said if a staff member were part of the allegation, they would be suspended immediately during the investigation.</p> <p>2. An admission Record revealed the facility admitted Resident #11 on 12/12/2024. According to the admission Record, the resident had diagnoses that included chronic obstructive pulmonary disease, congestive heart failure, generalized anxiety disorder, major depressive disorder, and chronic pain syndrome.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/22/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.</p> <p>Resident #11's Care Plan Report included a focus area initiated 07/26/2025, that indicated the resident had a behavior problem and became aggressive and accusatory with staff when frustrated. Interventions directed staff to assist the resident to develop more appropriate methods of coping and interacting and to meet the resident's needs.</p> <p>A report titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form, dated 07/26/2025, revealed that Resident #11 alleged that Housekeeper #28 pushed them at approximately 11:30 AM. The report indicated the incident was witnessed by a nurse and Certified Medication Aide (CMA) #26.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A report titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report Form, dated 07/28/2025, included a summary of an interview with the witness, CMA #26 and with the alleged perpetrator, Housekeeper #28. The summary with CMA #26 indicated Resident #11 followed Housekeeper #28 insisting that she go back to the resident's room to clean more. The summary indicated Resident #11 was angry and fell into the wall; Housekeeper #28 attempted to help the resident and the resident said Housekeeper #28 pushed the resident. The summary with Housekeeper #28 indicated Resident #11 came to find her to tell her that the resident's room was not clean, so she went back to the resident's room. The summary indicated Resident #11 fell into the doorway of their room and then yelled out that she [Housekeeper #28] had pushed the resident. There was no statement, however, from Resident #11 included in the report. There was no skin audit or trauma assessment for Resident #11 and no interviews from other residents included in the facility's investigation.</p> <p>During an interview on 10/11/2025 at 1:03 PM, the Regional Director of Operations stated there was no skin audit for Resident #11 on the date of the incident (07/26/2025) and no trauma assessment after the incident.</p> <p>During an interview on 10/11/2025 at 2:02 PM, the DON stated she could not recall whether a written statement was obtained from Housekeeper #28 even though the housekeeper's statement was summarized in the report. The DON also could not recall whether a written statement was obtained from Resident #11. Per the DON, other residents on the hallway were not interviewed about Housekeeper #28, since CMA #26 was present and witnessed the incident and they were able to unsubstantiate the abuse allegation in the moment.</p> <p>3. An admission Record revealed the facility most recently admitted Resident #33 on 09/15/2020. According to the admission Record, Resident #33 had a medical history that included diagnoses of muscular dystrophy, unspecified heart failure, and generalized muscle weakness.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/03/2025, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident was independent with a motorized wheelchair.</p> <p>Resident #33's Care Plan Report included a focus area initiated 10/03/2024, that indicated the resident was independent in fulfilling their leisure time and had a general willingness to participate in group programs. Interventions directed staff to check in with Resident #33 often to ensure their contentment with items provided for self-directed independent leisure (initiated 10/03/2024), and indicated the resident enjoyed various group programs and socializing with other residents/staff (initiated 10/03/2024).</p> <p>An admission Record revealed the facility admitted Resident #22 on 10/17/2025. According to the admission Record, Resident #22 had a medical history that included diagnoses of demyelinating disease of the central nervous system, other intervertebral disc degeneration, fibromyalgia, ataxia, bipolar disorder, muscular dystrophy, unspecified heart failure, and generalized muscle weakness</p> <p>A quarterly MDS, with an ARD of 07/26/2025, revealed Resident #22 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS revealed the resident did not exhibit any behavioral symptoms during the assessment look-back period. The MDS revealed Resident #22 was also independent with a motorized wheelchair.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Civic Avenue Salisbury, MD 21804	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #22's Care Plan Report included a focus area dated 07/17/2025 that indicated the resident smoked and was able to smoke independently.</p> <p>A Social Service Assessment, dated 07/09/2025, revealed Resident #33 reported they had not had any event that was unusually or especially frightening, horrible, or traumatic.</p> <p>Observation of and interview with Resident #33 on 10/08/2025 at 2:27 PM revealed they were in their room sitting upright in bed. Resident #33 was willing to discuss the details of the incident but was noted to have changes in voice quality during retelling. During an interview, Resident #33 stated that Resident #22 had been acting differently that day (08/24/2025) and Resident #33 believed that Resident #22 was intoxicated with an unknown substance. Resident #33 stated they were outside in the gazebo area and the resident was assisting Resident #22 with lighting their cigarette when Resident #22 started asking for some [vulgar slang term for a body part] Resident #33 stated they told Resident #22 to chill, and Resident #22 reached over and attempted to grab Resident #33's genital area. Resident #33 stated they blocked Resident #22's hands and then attempted to show them the ring worn on their left hand fourth finger. Per Resident #33, Resident #22 then grabbed Resident #33's left hand and attempted to open it and due to Resident #33's medical condition, they had to utilize their right hand to remove Resident #22's hands. At that time, Resident #33 left the gazebo and went back to their room. Resident #33 stated they limited their activity in the facility to prevent contact with Resident #22 and Resident #22's significant other, Resident #40. Resident #33 stated they felt like R#22's significant other had been watching them. The resident stated that on one occasion Resident #33 was waiting for a family member in the main lobby and Resident #22 and Resident #40 stared at the resident, making them feel uncomfortable and the resident elected to return to their room to wait for their family. Resident #33 stated this incident had triggered memories of childhood sexual molestation which had also led to their self-imposed isolation to their room. Resident #33 stated they had told everyone about the incident, but nothing had been done.</p> <p>During an interview on 10/08/2025 at 3:10 PM, Resident #22 stated that they had made a gesture of a male performing sexual self-gratification, and Resident #33 reported them for sexual harassment. Resident #22 denied having touched Resident #33 but reported they were unable to recall what was said during the incident on 08/24/2025.</p> <p>During an interview with Resident #40 on 10/09/2025 at 11:53 AM, it was revealed that they were present when the alleged incident occurred in the gazabo on 08/24/2025. They were reporting that Resident #33 made a gesture of a male sexually self-pleasuring themselves towards Resident #22 and Resident #40. Resident #22 then repeated the act, and that offended Resident #33. They believed the allegation was due to Resident #33 being jealous of Resident #22 and Resident #40's relationship status.</p> <p>During an interview on 10/09/2025 at 10:02 AM, Geriatric Nurse Aide (GNA) #27 revealed she did not know exactly what happened, but that it had to be something pretty drastic for Resident #33 and Resident #22 to stop interacting. She reported that since that time, Resident #33 did not seem to want to get out of bed.</p> <p>During an interview on 10/09/2025 at 10:45 AM, GNA #24 stated that Resident #33 and Resident #22 were not friends anymore, and Resident #33 was no longer visiting the 200 and 300 Units.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/14/2025 at 2:16 PM, Licensed Practical Nurse (LPN) #15 stated that on Sunday, 08/31/2025 at approximately 10:00 PM, Resident #33 activated their call light and asked to speak with her specifically. She stated Resident #33 was crying and visibly upset. Per LPN #15, Resident #33 reported that Resident #22 had previously touched them and on that night, Resident #33 had gone to the lobby to await family and Resident #22 and Resident #40 cursed at the resident. LPN #15 stated she immediately reported the incident to her supervisor, LPN #22, who contacted the Director of Nursing (DON). LPN #15 stated the DON instructed her to move Resident #33 to another unit. She stated she moved the resident; however, she stated when she returned to work on Monday, Resident #33 was back in their old room. LPN #15 stated that Resident #33 had not been coming out of the resident's room since the incident because the resident was scared. She stated she had noticed the resident coming out more that week.</p> <p>During an interview on 10/16/2025 at 9:05 AM, LPN #22 stated that she had contacted the DON and the Administrator on Sunday (08/31/2025) with the allegation (unable to recall allegation details) and the decision was made to move Resident #33 to the 500 Unit.</p> <p>During an interview on 10/11/2025 at 3:18 PM, Unit Manager (UM) #10 stated Resident #33 told her about the incident several days after the occurrence (unable to recall the exact date). She stated that the resident reported that they were helping Resident #22 to smoke when something sexual was said, but she could not remember the details. UM #10 stated they also recalled something about Resident #33 showing their promise ring and talking about the importance of the item to them. Per UM #10, Resident #33 was worried that Resident #22 and Resident #40 would retaliate against them; however, she stated that she had not seen any retaliation against Resident #33. She stated that she was unable to recall any further details from the report. UM #10 stated she immediately reported the allegation to the DON, and the Mental Health Nurse Practitioner had seen the resident. According to UM #10, there had been no changes in Resident #33's behavior since the incident.</p> <p>During an interview on 10/09/2025 at 11:25 AM, the DON and the Regional Director of Operations (RDO) revealed that Resident #33 had reported that Resident #22 made a comment about wanting [vulgar slang term for a body part], which made Resident #33 uncomfortable. The DON stated that she was also aware that Resident #33 felt like Resident #40 was watching them and that Resident #33 had elected to keep to themselves and not interact with the residents. Per the DON, they had treated this incident more from the perspective of the loss of friendship as the three residents had been friends prior to the incident. The RDO reported that they had interviewed Resident #33 the previous evening, and there was no report of physical contact made, and Resident #33 reported the incident as being an uncomfortable situation and did not describe the incident as being abuse or sexual abuse. Per the DON, the decision was made to have the Mental Health Nurse Practitioner provide talk therapy to both parties involved and she felt like the therapy had been helping. The DON reported that Residents #33, #22, and #40 had all been very good friends prior to the incident and believed that the loss of a friendship played some part in Resident #33's self-imposed isolation. However, due to Resident #33 not labelling the incident as abuse, she did not investigate the incident.</p> <p>On 10/12/2025 at 1:59 AM, a Removal Plan was submitted by the facility and accepted by the State Agency as follows:</p> <p>Corrective actions which will be accomplished for those residents found to have been affected.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> <li>1. Statements were obtained from involved residents #41, #22 and #33. Resident #11 is no longer in the facility. For resident #41, no new findings. For resident #22, no new findings. For resident #33, no new findings. Statements were completed on 10/11/25 by the nurse manager.</li> <li>2. Residents #41, #22, and #33 were assessed to ensure no injuries, physical or psychological, were present. For resident #41, no new findings. For resident #22, no new findings. For resident #33, no new findings. Assessments were completed on 10/12/25 by the nurse manager.</li> <li>3. RN #20 and Housekeeper #28 have been suspended on 10/11 /25 by the Regional Director of Operations.</li> <li>4. The administrator and director of nursing have been suspended on 10/11/25 by the Regional Director of Operations.</li> <li>5. Statements were obtained from the accused employees #20 and #28 by the Regional Nurse on 10/11/25.</li> <li>6. Social Services has met with involved residents #41, #22 and #33 to address any psychosocial concerns. There were no additional findings for Residents #41, #22, or #33, and Resident #11 is no longer in the facility. This was completed on 10/12/25 by the Director of Social Services.</li> <li>7. Residents #41 (allegation of physical abuse on 10/9/25) and #33 (allegation of sexual abuse on 10/11/25) responsible parties were made aware of the allegations.</li> <li>8. Police were notified of the allegations of physical and sexual abuse on 10/9/25 and 10/10/25.</li> <li>9. Maryland Department of Health was notified of the allegations of physical and sexual abuse by 10/11/25.</li> <li>10. Medical Directors were notified of the allegations of physical and sexual abuse for residents #41 and #33 on 10/11/25.</li> <li>11. Ombudsman was notified of the allegations of physical and verbal abuse by 10/12/25.</li> <li>12. Trauma informed evaluations were completed for identified residents #41 and #33 on 10/11/25.</li> </ol> <p>Measures that will be put in place and systemic changes that will be made to ensure that the practices do not recur.</p> <ol style="list-style-type: none"> <li>1. 248 current employees will receive education regarding investigation of abuse. Education began on 10/10/25 and to be completed by 10/12/25 by the nurse manager.</li> <li>2. Nurse managers and social workers will be educated on abuse investigation. This started on 10/10/25 and was completed on 10/11/25 by the nurse manager.</li> </ol> <p>How the corrective actions will be monitored to ensure the practices will not re-occur.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. AD Hoc QAPI was held on 10/11/25. To ensure all residents were free from abuse, the decision was made to place the Administrator and Director of Nursing on Administrative leave.</p> <p>2. The QAPI was reviewed by the Medical Director on 10/12/25.</p> <p>Allegation of Compliance</p> <p>1. The facility alleges compliance with this plan on 10/12/25.</p> <p>2. The immediacy of the IJ was removed on 10/12/25.</p> <p>Onsite Verification of Removal Plan:</p> <p>The IJ was removed on 10/13/2025 after the survey team completed onsite verification that the Removal Plan had been implemented. Noncompliance remained at the lower scope and severity of G. Verification was completed as follows:</p> <p>1. Witness statements from Residents #22, #33, and #41 were obtained by the DON.</p> <p>2. Resident #22's weekly skin check assessment dated [DATE] revealed no new skin impairments were identified, and the social services assessment dated [DATE] revealed the facility identified that the resident had a history of past sexual/physical abuse and was currently receiving psychiatric services. Resident #33's weekly skin assessment dated [DATE] revealed no new skin impairments were identified, and a social service assessment dated [DATE] revealed the resident had felt numb and detached, been on guard, watchful, or easily startled, and been trying hard to not think about the events. Resident #41's weekly skin check dated 10/09/2025 revealed no new skin impairments were identified, and a social service assessment dated [DATE] revealed the resident had no verbal indicators or emotional distress/anxiety.</p> <p>3. Registered Nurse (RN) #20's timecard sheet revealed their last date worked was on 09/29/2025 and Housekeeper #28's last date worked was on 10/11/2025.</p> <p>4. Record review revealed the RDO placed the Administrator and DON on administrative leave on 10/11/2025.</p> <p>5. Record review revealed the facility obtained statements from RN #20 and Housekeeper #28 of their witness accounts of the allegations against them.</p> <p>6. Record review revealed social services staff met with Resident #33 on 10/11/2025 and identified the resident as self-isolating and feeling guilty. Record review revealed social services staff met with Resident #41 on 10/11/2025 and identified no verbal indicators or emotional distress/anxiety during assessment.</p> <p>7. Record review revealed Resident #33's representative was made aware of the abuse allegation on 10/11/2025 at 9:56 PM, and Resident #41's representative was made aware of the abuse allegations on 10/09/2025 at 3:15 PM.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>8. Record review revealed the RDO notified the Medical Director of the allegation of physical abuse for Resident #41 and sexual abuse for Resident #33.</p> <p>9. Record review revealed Local Law Enforcement were notified of Resident #33's allegation of sexual abuse allegation and Resident #41's allegation of physical abuse allegation on 10/10/2025 and 10/09/2025, respectively.</p> <p>10. Record review revealed the facility notified the SSA of Resident #41's physical abuse allegation on 10/09/2025 and Resident #33's allegation of sexual abuse on 10/09/2025.</p> <p>11. Record review revealed Medical Directors were notified of the allegations of abuse on 10/11/2025.</p> <p>12. Record review revealed the facility notified the Ombudsman of the allegations of abuse Resident #41 and Resident #33 on 10/12/2025.</p> <p>13. Record review revealed Resident #33's trauma assessment completed on 10/11/2025 identified past sexual abuse and Resident #41's trauma assessment completed on 10/11/2025 [NAME]</p>		

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<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor.</p> <p>(continued on next page)</p>

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<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review, and facility policy review, the facility failed to ensure therapy services were provided in accordance with physician orders for 1 (Resident #31) of 4 residents sampled for therapy services. Findings included: A facility policy titled, Physician Orders, updated 01/2025, revealed, 5. The provision of care and services in accordance with the physician orders will be documented in accordance with professional standards of practice. An admission Record revealed the facility admitted Resident #31 on 03/10/2025. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and muscle wasting and atrophy. The admission Record revealed Resident #31 was discharged home on [DATE]. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/16/2025, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident required substantial/maximum assistance with toileting hygiene, was dependent on staff assistance with showering and bathing themselves and required partial/moderate assistance with personal hygiene. The MDS revealed the resident received three individual days of therapy, for at least 15 minutes a day, during the assessment lookback period. Resident #31's Care Plan Report, included a focus area initiated 03/11/2025, that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to cerebral vascular accident (CVA), hemiparesis, and hemiplegia. Interventions directed staff to provide Physical Therapy (PT)/Occupational Therapy (OT) evaluation and treatment as ordered (initiated 03/11/2025) and encourage the resident to participate in ADLs to the fullest extent possible (initiated 03/11/2025). Resident #31's Order Summary Report, for the timeframe from 03/10/2025 through 06/18/2025, contained an order dated 03/11/2025 with an end date of 04/10/2025, for PT evaluation and treatment five times a week for 30 days for bed mobility, transfer and gait training, balance retraining, therapeutic activities (TA), therapeutic exercise (TE), group therapy, patient caregiver education, and discharge planning. The Order Summary Report contained an order dated 04/17/2025 with an end date of 05/17/2025, for a late entry PT monthly recertification starting on 04/11/2025, and continuation of PT treatment five times a week for 30 days with current plan of care (POC). The Order Summary Report contained an order dated 05/13/2025 with an end date of 06/12/2025, for a PT monthly recertification and continuation of PT treatment five times a week for 30 days with current POC. Resident #31's Physical Therapy Treatment Encounter Note(s), dated 03/11/2025 to 06/17/2025, revealed the resident received PT three times (03/31/2025, 04/01/2025, and 04/02/2025) for the week of 03/30/2025 to 04/05/2025. The Physical Therapy Encounter Note(s) revealed no documentation as to why the resident received PT three times instead of five times as ordered. During an interview on 10/15/2025 at 9:46 AM, the Director of Rehabilitation (DOR) stated residents were evaluated upon admission to the facility for therapy services, which would determine if therapy was needed for the resident. The DOR stated the evaluation was sent to the resident's physician, who signed off on the evaluation, and the orders were entered into the electronic health record by the evaluating therapist. The DOR stated Resident #31 was scheduled to have PT sessions on 04/03/2025 and 04/04/2025, but there was no documentation as to why the resident did not receive PT on those dates. The DOR stated she would expect therapy staff to document a reason as to why a resident did not receive therapy on a certain date. During an interview on 10/15/2025 at 10:13 AM, Physical Therapy Assistant (PTA) #42 stated she worked with Resident #31 most days during PT sessions and could not state why the resident did not receive therapy on 04/03/2025 or 04/04/2025 as scheduled. During an interview on 10/17/2025 at 4:33 PM, the Interim Director of Nursing (Int. DON) stated she would expect residents to receive therapy services as ordered and for therapy staff to communicate with nursing staff about any refusals of therapy services or if the resident was out of the facility. During an interview on 10/17/2025 at 5:26 PM, the Regional Director of Operation (RDO) stated he would expect residents to receive therapy services as ordered by the resident's physician.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review, and facility policy review, the facility failed to maintain a complete and accurate medical record for 3 (Residents #32, #31, and #30) of 48 sampled residents. Findings included: A facility policy titled, Guidelines for Charting and Documentation, revised in 04/2012, revealed, The purpose of charting and documentation is to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc.[et cetera, and so forth], and the progress of the resident's care; 2. Guidance to the physician in prescribing appropriate medications and treatments; 3. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident; 4. Nursing service personnel with a record of the physical and mental status of the resident; 5. Assistance in development of a Plan of Care for each resident; 6. A legal record that protects the resident, care providers, and the facility; and 7. A source of all resident charges. The policy revealed, c. Current lists of orders must be maintained in the clinical record of each resident. The policy revealed the section titled, 2. Contents of Orders, included, i. [brand name] Catheter: 1. If PRN [pro re nata, as needed], specify why it is needed. 2. Specify the size (i.e. [id est, that is], #18 Fr [French] [brand name] cath [catheter] to straight drain) and the frequency of change. 3. Catheter care - specify what is to be done or 'according to facility procedure.' A facility policy titled, Physician Orders, updated 01/2025, revealed, 5. The provision of care and services in accordance with the physician orders will be documented in accordance with professional standards of practice. 1. An admission Record revealed the facility admitted Resident #32 on 05/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of unspecified cirrhosis of liver and other ascites. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2025, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had an indwelling catheter for urinary elimination. Resident #32's Care Plan Report, included a focus area initiated 05/23/2025, that indicated the resident had an indwelling urinary catheter. Interventions directed staff to provide urinary catheter care every shift and as needed (initiated 05/23/2025). Resident #32's Order Summary Report, for the timeframe from 05/23/2025 through 06/05/2025, contained no order related to indwelling catheter care. An Admission/ readmission Screener, dated 05/23/2025 and completed by Licensed Practical Nurse (LPN) #49, revealed Resident #32 had an indwelling catheter for urinary elimination upon admission. A Nursing Daily Skilled Pathway, dated 05/24/2025, revealed Resident #32 had an indwelling catheter for bladder function and received catheter care every shift. During an interview on 10/14/2025 at 11:20 AM, the Nurse Practitioner (NP) stated she did not remember if Resident #32 had an indwelling catheter during their time at the facility. The NP stated she would expect the resident's order set to have orders for catheter care every shift and to monitor the catheter daily. During an interview on 10/16/2025 at 5:30 PM, LPN #49 stated that when a resident was admitted to the facility with an indwelling catheter, nursing staff would conduct an admission assessment. LPN #49 stated if an indwelling catheter was noted during the admission assessment, the assessment should trigger the batch orders related to indwelling catheter care automatically. LPN #49 stated she did not remember Resident #49 and whether the resident had an indwelling catheter and could not recall if she entered the orders for the resident's catheter care on admission. During an interview on 10/17/2025 at 4:33 PM, the Interim DON (Int. DON) stated that when a resident was admitted to the facility, the admitting nurse should review the hospital documentation and discharge summary and assess the resident upon admission to form the resident's order set. The Int. DON stated that once the physician approved the orders, the orders would be entered into the electronic health record. The Int. DON stated devices such as catheters and intravenous lines had batch orders that would be triggered and would include care and maintenance of the device. The Int. DON stated she would expect catheter care to be completed every shift, whether there was an order for catheter care or not. During an interview on 10/17/2025 at 5:26 PM, the Regional Director of Operations (RDO) stated he would expect nursing staff to review a resident's discharge summary and hospital documentation upon admission to the facility and enter the appropriate orders as written and reconcile the orders with the resident's physician. The RDO stated he would expect nursing staff to obtain any orders pertinent to the care and treatment of the resident. The RDO stated he would expect staff to document care the resident received in the resident's medical record. 2. An admission Record revealed the facility admitted Resident #31 on 03/10/2025</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2025
NAME OF PROVIDER OR SUPPLIER  Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Civic Avenue Salisbury, MD 21804	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/17/2025
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff consistently and correctly implemented infection control practices. Specifically, the facility failed to:- ensure enhanced barrier precautions were followed during wound care for 1 (Resident #28) of 2 residents observed during wound care.- ensure catheter care and hand hygiene were performed in accordance with professional standards of practice and facility policy for 2 (Resident #44 and Resident #45) of 2 residents observed during catheter care. Findings included:1. A facility policy titled, Enhanced Barrier Precautions, revised 12/2024, indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. The policy further indicated, Enhanced barrier precautions apply when: a. A resident is infected or colonized with a CDC [Centers for Disease Control and Prevention]-targeted MDRO, but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained: b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices and does not have secretions or excretions that are unable to be covered or contained: and c. Contact precautions do not otherwise apply. The policy specified, EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing high contact resident care activity (as opposed to before entering the room). The policy indicated, Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. providing hygiene or grooming; d. changing briefs or assisting with toileting; e. transferring; f. providing bed mobility; g. changing linens; h. prolonged high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin (e.g. [for example], in the shower room, therapy gym, or during restorative care); i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc. [et cetera].); and j. wound care (any skin opening requiring a dressing). A facility policy titled, Handwashing/Hand Hygiene, revised 10/2023, indicated, The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. The policy specified, Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. The policy indicated, The use of gloves does not replace hand washing/hand hygiene. An admission Record revealed the facility admitted Resident #28 on 10/01/2025. According to the admission Record, the resident had a medical history that included diagnoses of methicillin-resistant Staphylococcus aureus (MRSA) infection as the cause of diseases classified elsewhere and resistance to multiple antibiotics. Resident #28's Care Plan Report included a focus area initiated 10/02/2025 that indicated the resident required enhanced barrier precautions related to having a central line. Interventions directed staff to use gloves and gown during high-contact care activities including dressing, bathing, showering, transferring, providing hygiene care, changing linens, changing briefs, assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy, ventilator), and wound care (any skin opening requiring a dressing) (initiated 10/02/2025). Resident #28's October 2025 Order Summary Report contained an order dated 10/02/2025 for wound care to the right foot, to cleanse with normal saline, apply iodine gel to a 2-inch by 2-inch (2x2) gauze pad then to wound bed, then cover with an abdominal pad, rolled gauze, and a self-adhesive bandage wrap daily and as needed. The Order Summary Report contained an order dated 10/02/2025 for wound care behind the left ear, to cleanse with normal saline, pat dry, pack with Betadine-moistened 1/4-inch plain packing, and cover with a band aid two times a day and as needed. During an observation of wound care for Resident #28 on 10/08/2025 at 12:04 PM, Licensed Practical Nurse (LPN) #44 performed hand hygiene, donned clean gloves, and sanitized a bedside table. LPN #44 removed her gloves, performed hand hygiene, and donned clean gloves before gathering wound care supplies and placing them on the bedside table. A sign was observed on the door of Resident #28's room indicating the resident was on enhanced barrier precautions. After performing hand hygiene, LPN #44 entered the resident's room without donning an isolation gown, donned clean gloves, and performed wound care for Resident #28's wounds as ordered. LPN #44 disposed of the used items, removed her gloves, and performed hand hygiene before exiting the resident's room. During an interview on</p>		