STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215092	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Collingswood Rehabilitation and Healthcare Center	299 Hurley Avenue Rockville, MD 20850

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on medical record review and interview, the facility staff failed to report an injury of unknown origin of a resident timely to the State of Maryland's OHCQ. This was evident for 2 (Resident # 2, #8) out of 4 resident records reviewed for alleged injuries of unknown origin during a complaint survey. The Finding include: 1) Review of facility reported incident #2682365 on 1/5/25 at 11:35 AM revealed Resident #8's family member sent an email to the Assistant Director of Nursing (ADON) on 11/18/25 reporting they noticed a contusion on Resident #8's right upper arm while visiting on 11/14/25. Upon investigation, the facility interviewed Staff #2, the Geriatric Nursing Assistant (GNA) who was assigned to care for Resident #8 on 11/14/25. Staff #2's written statement revealed Resident #8's family member reported to her that they noticed a skin issue on Resident #8 at approximately 2:30 PM on 11/14/15. She prepared to check the resident, but the family member indicated that the resident was asleep and asked Staff #2 to not disturb him/her. Staff #2 indicated that she did not check the resident and unintentionally forgot to report this to the nurse before leaving for the day. In an interview on 1/6/25 at 12:13 PM Staff #2 confirmed this information. She confirmed that she did not report the information to anyone. The facility did not report Resident #8's injury of unknown origin to the state facility until 11/18/25 when the family member emailed the ADON. This was 4 days after a potential injury was identified by the resident's family and reported to Staff #2. 2)On 12/8/25, the Office of Health Care Quality received a Facility Reported Incident (FRI) report (MD2687438) which reported the alleged injury of unknown origin of Resident #2. The FRI investigation stated that Resident #2 was observed on 12/5/25 with a bruise to the right thigh. The investigation was unable to discover how the resident received the bruise. Review of the FRI investigation on 1/6/26 at 8:15am revealed Resident # 2's right thigh injury was observed, reported and treated on 12/5/25 by nursing staff. When nursing staff reported the injury of unknown origin to Dementia Unit Manager #3 on 12/5/25, Dementia Unit Manager #3 failed to report Resident #2's injury to the Director of Nursing or Administrator. Administration didn't become aware of Resident #2's injury of unknown origin until 12/8/25 causing a late reporting of the injury to OHCQ. During the surveyor's interview with Dementia Unit Manager #3 on 1/6/26 at 1:32pm, he/she admitted failure to contact the Administrator or Director of Nursing regarding Resident #2's injury on 12/5/25 after nursing staff made them aware of the injury. When Dementia Unit Manager #3 reviewed nursing staff paperwork on Resident #2's injury on 12/8/25, he/she realized that the injury was considered an injury of unknown origin and reported the injury to the Director of Nursing. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 1/6/26 at 1:45pm, the surveyor expressed concern that the Dementia Unit Manager #3 failed to report Resident #2's injury of unknown origin on 12/5/25. The Administrator confirmed that the facility reported Resident #2's injury of unknown origin late. The injury was reported to OHCQ on 12/8/25.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility reported incident investigations and interview it was determined the facility 1) failed to thoroughly investigate an allegation of abuse and 2) injuries of unknown source. This was evident for 1 (Resident #3) of 2 residents reviewed for abuse, and 1 (Resident #7) of 3 residents reviewed for injury of unknown source during the complaint survey. The findings include: 1) On 1/5/26 at 2:43 PM, an initial review of a facility reported incident, 2663799, alleged Resident #3 had been abused. The self-report documented on 11/7/25, around 1:15 PM, Resident #3 gave the Unit Manager (UM) a handwritten note that alleged s/he had been abused by staff during care on his/her 2nd day of admission. The resident did indicate what shift the alleged abuse occurred or identify any staff. Resident #3 was admitted to the facility on [DATE], indicating the alleged abuse occurred on 11/5/25, At that time, a brief review of the medical record revealed Resident #3 was admitted to the facility on [DATE] following an acute hospitalization. The resident was alert and oriented and had multiple diagnosis with complex medical needs. Review of the facility's investigation revealed a copy of a handwritten note from Resident #3 alleging that on the 2nd day of his/her admission to the facility, the resident was beaten up during bath time. No staff or shift was identified In the note. On 1/6/26 at 9:50 AM, a continued review of the facility's investigation documents found no documentation to indicate that after staff became aware of Resident #3's allegation of abuse, an interview had been conducted with Resident #3 about his/her allegations. In addition, no documentation was found to indicate the facility conducted interviews related to the allegations with residents who resided on the unit. Instead, a statement was obtained from the resident representative for Resident #10, Resident #11, and Resident #12. A brief review of the medical record revealed documentation that Resident #10, Resident #11 and Resident #12 were cognitively impaired and not interviewable. No documentation was found in the facility's investigation to indicate why residents were not interviewed during the facility's investigation of the allegation. On 1/6/25 at 3:50 PM, Assistant Director of Nurses (ADON) was made aware there was no evidence the resident was interviewed regarding his/her allegation of abuse, and no resident interviews were included in the facility's investigation. The ADON acknowledged the concerns and offered no further comments at that time. Review of staff interview statements obtained from staff who worked with Resident #3 on 11/5/25 revealed a statement from the nurse and GNA who worked the 7 AM to 3 PM shift, and the nurse and GNA who worked 3 PM to 11 PM shift. No documentation was found to indicate staff interviews were obtained from the nurse (Staff #13, RN) and the GNA (Staff #12) assigned to care for Resident #3 during the 11 PM to 7 AM shift on 11/5/25. In addition, no written statement was found from Staff #10, RN, UM, the nurse who received the handwritten note with the allegation of abuse from Resident #3. On 1/6/25, at approximately 4:00 PM, a typed document with the heading Incident statement regarding [Resident #3] was reviewed. The document stated when social services went to visit Resident #3 regarding an incident s/he reported to staff, the resident declined to talk about it and declined to write a statement. The statement was undated and was followed by an unclear signature. The statement did not identify the author of the statement, who from social services went to speak with the resident, or what incident the writer was referring to. On 1/6/25 at 4:32 PM, the NHA was made aware that no documentation in the facility's investigation and the resident's medical record to indicate Resident #3 was interviewed about his/her allegation of abuse and the concerns with failing to obtain staff and resident interviews was discussed with the NHA. The NHA acknowledged the concerns and stated that when the social worker, who is no longer at the facility, asked Resident #3 what happened, the resident didn't want to talk. 2) On 1/7/26 at 10:51 AM, a review of facility reported incident 2680766 alleged (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 had a right wrist fracture that was an injury of unknown source. The facility's initial self-report documented that on 11/28/25, at approximately 2:30 PM, while the nurse and GNA were providing the resident incontinence care, Resident #7, displayed a facial grimace upon movement of his/her right arm. The physician was notified, and a stat x-ray of the resident's right wrist was ordered. On 11/28/25, an x-ray of Resident #7's right wrist revealed a suspected hairline fracture to right wrist. On 12/2/25, Resident #7 was sent to the hospital for an orthopedic evaluation where an X-ray of the resident's right wrist was completed and revealed there was no fracture. Review of Resident #7's medical record revealed the resident was admitted to the facility in mid-October 2025 with multiple diagnosis & complex medical needs. The record documented Resident #7 had severe cognitive impairment and ventilator (machine that helps you breath) dependent. Review of the facility's investigation documents revealed 3 employee statements related to the alleged injury of unknown source. There was a statement from Staff #14, RN, and Staff #15, GNA, the staff who were providing care to Resident #7 on 11/28/25 when the resident was observed with a facial grimace with right arm movement, and an interview from Staff #16, GNA who was not assigned to the resident, but assisted with the resident's care on 11/28/25. There was no other documentation found to indicate interviews were conducted with staff who had worked with the resident on any preceding shift or day. In addition, there was no documentation found to indicate that any residents had been interviewed in response to the allegation of an injury of unknown source. On 1/7/26 at 2:01 PM, the concerns with failing to interview staff and failing to interview residents when investigating an injury of unknow source was discussed with the NHA and the Regional Director of Operations. The NHA acknowledged the concerns and offered no further comments a that time.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff it was determined the facility failed to ensure each resident's medical record was complete and accurately documented. This was evident for 1 (Resident #5) of 3 residents reviewed for Quality of Care during the complaint survey.The findings include: The facility's investigative documentation related to Facility Reported Incident #2677827 was reviewed on 1/6/26 at 1:05 PM. The documentation revealed Resident #5, who was his/her own decision maker, failed to inform staff and left the faciity on [DATE] at approximately 2:00 AM. Staff initiated proper protocol and later determined the resident had returned home safely. Further review of the documentation revealed Resident #5 was presented with a notice of non-coverage on 11/21/25 which indicated the resident's last date of insurance coverage (LCD) for his/her stay in the facility would be 11/22/25. The notice included the resident's right to appeal the discharge. The resident signed the notice. Review of the resident's medical record on 1/6/25 at 1:45 PM revealed a Social Services (SS) Progress note dated 11/21/25 1:24 PM by Staff #9 the Social Services Assistant. The note indicated she received the notice for LCD of 11/22/25 and the resident would discharge on [DATE]. Her documentation indicated that the resident was ready to go home and would go home on Saturday (11/22/25) instead of Sunday (11/23/25). The note included that SS would set up home health and the resident indicated s/he could go home in a taxi. An interview was conducted with Staff #9 on 1/7/25 at 10:47 AM. She was asked to explain how she was involved in Resident #5's discharge and what steps were taken to discharge him/her. She indicated that she provided the cut letter to Resident #5 and she called his/her family member who was involved in Resident #5's care. She indicated that she informed them of the discharge date . The family member indicated they wanted to appeal and wanted to talk to Resident #5 about it. She added that the family member thought Resident #5 needed more time before leaving the facility. Staff #9 indicated that she notified staff that there would be an appeal and Resident #5 would be staying and that she later told Resident #5 that his/her family member wanted him/her to stay and they would call him. Resident #5 indicated okay. She confirmed that she did not document the updated discharge plan information in Resident #5's medical record. Staff #5 the Regional Director of Operations and the facility Administrator were made aware of these concerns on 1/7/26 at 1:30 PM.