STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215123	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadmead	13801 York Road Cockeysville, MD 21030

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a tour of the kitchen, observation, and staff interview, it was determined that the facility staff failed to label stored food items to ensure safety and prevent contamination which could lead to unsafe food and potential illness.The findings include:During the initial tour of the kitchen on 11/17/2025 at 08:00 AM, the following items were found opened and used without any labeling:Walk in Refrigerator #1:1gallon [NAME] sauce w/ red raspberries1gallon sweet baby rays BBQ sauce x2 bottles1 gallon buffalo sauce x 2 bottles1 gallon each of salad dressings; Ranch, Golden Italian and French3 pound Hummus container1 32 oz horse radish containerWalk in Refrigerator #2:1 gallon Mayo1 gallon Harachino sauce 1 gallon pickle chips During an interview with staff # 8 on 11/17/2025 at 08:15 AM, he/she stated that all items that are opened and or used should have had a label with a use by date. Staff # 8 also stated that staff will need to be re-educated on labeling and dating of food items. On 11/19/2025 at 10:12 AM, the Nursing Home Administrator was made aware of the findings in the kitchen and acknowledged the concern.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interviews, it was determined that the facility failed to maintain accurate records of staff COVID-19 vaccination status. This deficiency was evident for four (Staff #10, #11, #12, and #13) of the five staff reviewed for COVID-19 vaccinations. The findings include:On 11/19/25 at 11:33 AM, the surveyor reviewed the immunization records for five recently hired staff members who provide direct resident care. The staff reviewed included: Staff #10 and #11 (Hired May 2025), Staff #12 (Hired October 2025), and Staff #13 (Hired August 2025).The review revealed that four out of the five staff did not have records documenting their COVID-19 vaccination status.In an interview with the Infection Preventionist (Staff #5) and the Director of Nursing (DON) on 11/19/25 at 12:18 PM, they confirmed that the facility staff immunization records are managed by Human Resources (HR).During an interview with the HR Director (Staff #16) on 11/19/25 at 1:14 PM, she stated that the facility did not collect data regarding employees' COVID-19 vaccination status.At 1:34 PM on 11/19/25, the DON and Staff #5 presented a spreadsheet detailing facility staff's COVID-19 vaccination status, including dates of initial vaccine, booster, and additional doses. However, the spreadsheet did not contain any data for Staff #10, #11, #12, or #13. The surveyor asked Staff #5 and the DON how the facility monitors and/or offers the COVID-19 vaccine to new staff hires, but they did not provide an answer.On 11/20/25 around 1:00 PM, the surveyor shared the above concerns with the DON, and she validated the deficiency.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on a review of the clinical record and staff interviews, it was determined that facility staff failed to properly document the primary decision maker for end-of-life decisions. This deficiency was evident in one (Resident #23) of the five residents reviewed for Advanced Directives during this annual survey.The findings include:The Medical Orders for Life-Sustaining Treatment (MOLST) form ensures that a patient's wishes to receive or decline care are honored. During the admissions process, a practitioner must review the MOLST form.Decision-making capacity is the ability of an individual to make an informed choice about a specific situation, such as medical treatment.On 11/17/25 at 1:12 PM, a review of Resident #23's medical record revealed that the resident's capacity certification was completed by two physicians on 7/21/25 and 7/22/25. Both physicians documented that the resident was not capable of making and communicating decisions regarding medical care.However, the MOLST dated 8/22/25 indicated that the orders were entered as a result of a discussion with and the informed consent of the patient. This contradicts the earlier capacity certifications.In an interview on 11/18/25 at 8:53 AM, the Social Worker (Staff #3) explained that physicians are supposed to review residents' decision-making capabilities and MOLST based on the resident's health condition, and then Social Workers review them. The surveyor reviewed Resident #23's MOLST and capacity certifications with Staff #3. The staff member acknowledged that two certifications indicated the resident was not capable of making decisions, yet the MOLST was signed by the resident afterward.In an interview with the DON (Director of Nursing) on 11/20/25 around 1:00 PM, the surveyor shared the concern, and the DON validated it.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of resident medical records and interviews with facility staff, it was determined that the facility failed to ensure residents received treatment and care to promote the highest practicable well-being evidenced by inadequate provision/monitoring of care when a resident experienced a voiding issue. This was evident for one (Resident #45) of 14 resident care records reviewed during this annual survey.The findings include:On 11/18/25, at 10:27 AM, the surveyor reviewed system-selected residents' closed records. The review revealed that Resident #45 was discharged from the facility on 9/18/25. A further review of Resident #45's progress notes revealed that the resident reported dark, tea-colored urine on 9/17/25, at 10:30 PM. An additional progress note, written on 9/19/25, at 2:07 AM, stated: Resident left AMA (against medical advice) overnight around 11:30 PM. Reports he/she was not urinating and concerned about the color of urine. [Spouse] was with him/her and took him/her via wheelchair by car with all belongings. They refused to sign the AMA papers and did not want to go by ambulance. Furthermore, there were several progress notes regarding Resident #45's urinary difficulty upon admission.On 11/20/25, at 8:00 AM, the surveyor reviewed Resident #45's discharge summary from the hospital prior to their admission to the facility. The record stated that the resident was hospitalized from [DATE], to 9/12/25. During this stay, the resident had a cystourethroscopy with lithotripsy (a procedure to remove urinary tract stones by using a cystoscope to examine the bladder and urethra). The discharge summary instructed a urology follow-up within 7-10 days after discharge. However, there was no documentation of Resident #45's urology follow-up in the resident's record.During an interview with the Director of Nursing (DON) on 11/20/25, at 10:32 AM, she explained that the urology appointment was originally scheduled for 9/15/25, at 1 PM. The DON added, We contacted the urologist's office and verified that the resident did not attend the appointment. Since there was no documentation, we don't know why. Additionally, the surveyor asked how the facility monitored and/or provided care for Resident #45's voiding issues upon admission, especially after dark urine was noted on 9/17/25. The DON verified that Resident #45's health condition was not monitored and/or appropriate care was not provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interview, it was determined that the facility failed to 1) label oxygen tubing with date of change to indicate maintenance of the tubing for proper hygiene and safety, and 2) provide necessary respiratory care services for residents by failing to administer oxygen as prescribed. This was evident for three (Resident #23, #46, and #49) of 3 residents reviewed for respiratory care during this survey.The Findings include: 1) During the screening phase of the survey process on 11/17/25 at 10:30 AM, surveyor observed Resident # 46 and Resident # 49 receiving oxygen through nasal cannula tubing without a label indicating when they were changed. On 11/17/25, record review of resident # 46 noted an order for Oxygen at 2L – 4L/min via nasal cannula every shift for Cardiopulmonary Disorder (COPD). Resident # 49 had an order for Oxygen at 2L/min continuously every shift for Cardiopulmonary Disorder (COPD). On 11/18/25 at 09:30 AM, continued observation was made that the oxygen tubes were not labeled. During an interview with staff # 6, when asked about the nasal cannula tubing for oxygen administration, she/he stated that an order is written for oxygen, and the resident get hooked up to an oxygen tank or an oxygen concentrator, and the nursing staff ensure that the oxygen tubing is changed weekly. When asked if the oxygen tubing should be labeled, staff # 6 stated that the humidifier should be labeled but was unsure about the oxygen tubing. An interview was conducted on 11/18/2025 at 09:51 AM with staff #9. When asked about the nasal cannula tubing for oxygen administration, she/he stated that oxygen was administered continuously through nasal cannula tubing with humidified air and the tubing and the humidifier should be labeled every time that they were changed out. The surveyor requested that staff # 9 verify that Resident # 46 and Resident # 49 oxygen tubing were not labeled. Staff # 9 stated that they should have been labeled. During an interview with the Director of Nursing (DON) on 11/18/25 at approximately 2:00 PM, the surveyor informed her about the concern of the finding regarding the oxygen tubing not labeled with a date of change. The DON stated that the oxygen tubing should have been labeled and acknowledged the concern. 2) During an observation of Resident #23's oxygen tank and tube on 11/18/25 at 7:45 AM, it was noted 3 L (Liters) of oxygen was being administered to the resident through a nasal cannula. However, a review of Resident #23's order showed: 'Oxygen at 4 L/min via Nasal Cannula for SOB (Shortness of Breath).' On 11/18/25 at 7:48 AM, the surveyor asked Licensed Practical Nurse (LPN #2) to verify the amount of oxygen administered to Resident #23. LPN #2 observed the flow meter and confirmed the setting was 3 L/min at the moment. The surveyor asked what the order was for Resident #23. LPN #2 said, Yes, the order is 4 L/min, and then she adjusted the flow meter to 4 L. During an interview with the Director of Nursing (DON) on 11/18/25 at approximately 2:00 PM, the surveyor informed her of the finding regarding Resident #23's oxygen administration dose. The DON acknowledged the concern.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, medical record review, and interview with facility staff, it was determined that the facility failed to ensure that the environment of resident care was maintained in a manner that minimized the potential spread of infection, evidenced by an oxygen tube lying on the floor in a resident's room. This was evident for one (Resident #23) of two residents observed for oxygen therapy during this annual survey.The findings include:During the initial tour of the facility on 11/17/25 at approximately 10:00 AM, it was observed that Resident #23's oxygen tank was in the bathroom of his/her room, and the oxygen tube was lying on the floor from the tank to the resident's bed.The second observation, on 11/18/25 at 7:45 AM, noted that Resident #23's oxygen tube was still lying on the floor from the bathroom to the bed.In an interview with a Licensed Practical Nurse (LPN #2) on 11/18/25 at 7:45 AM, she stated that the facility's nurses manage residents' oxygen, including the tank, tube, and humidifier. The surveyor asked to observe Resident #23's oxygen tube. LPN #2 verified that the tube was lying on the floor and she said, It's not supposed to be touching the floor, but the resident kept it on the floor because of a behavior issue. We have documented this.On 11/18/25 at 8:20 AM, the surveyor reviewed Resident #23's progress note. The review revealed that there were several documentations regarding the resident's behavior, such as removing oxygen tubing and a lack of safety awareness. However, there was no documentation regarding the oxygen tube placed on the floor.During an interview with the Director of Nursing (DON) on 11/18/25 at approximately 2:00 PM, the surveyor asked about managing the oxygen tube. She verified that the tube should not be placed on the floor due to infection prevention. The surveyor shared the above concern, and the DON acknowledged the concern.