STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215137	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrooke CT Skilled Care Ctr at Bayleigh Chase	501 Dutchman's Lane Easton, MD 21601

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on facility reported incidents, record review and interview with facility staff it was determined that the facility staff failed to protect residents against incidents of abuse, and ensure measures were put in place to prevent further incidents of abuse. This was evident for 3 (#905, #901, and #45) of 9 residents reviewed for abuse. The facility was notified of the immediate jeopardy at 4:40 PM on 1/13/25. The facility developed a plan to sufficiently remove immediacy, which was reviewed and accepted after 3 attempts, at 6:37 PM on 1/13/2025 while surveyors remained onsite. The plan to remove immediacy that was presented to surveyors included: Resident #905 passed on 8/2/23, Resident #901 passed on 2/22/23. Resident #45 was interviewed on 1/8/25 by the social worker regarding his/her abuse claim. The facility reported the incident to the state on 1/8/25. A 5-day investigation was completed and submitted on 1/13/25. The conclusion was that alleged abuse could not be substantiated. GNA #1 was removed from resident #45 ' s care on 1/8/25. All residents in GNA #1 ' s group were interviewed by the social worker on 1/13/25 with no concerns identified. All other residents in WillowBrooke Court will be interviewed by nursing and the social worker on 1/13/25 to ensure there is no suspected abuse or neglect. Training on Abuse, Neglect, Reporting & Investigation was conducted by the Regional Clinical Director to the Director of Nursing (DON) & Assistant Director of Nursing (ADON). All team members currently working were educated on Abuse & Neglect Policy and protocol focusing on report abuse as soon as possible, obtaining witness statements, suspension pending investigation, Acts policy and state regulations on Abuse & Neglect, & who the abuse coordinator of the community is on 1/13/25 by nursing management (DON/ADON). The rest of the team members working in WillowBrooke Court will complete training by 1/17/25 by nursing management (DON/ADON). For those team members not on the schedule to work the training will be conducted by the DON and ADON by phone by 1/17/25. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The management team (NHA, DON, & ADON) will round twice a week to randomly interview 5% of the current residents on different shifts and different times regarding the quality of their care and monitor team members' interaction with residents for 6 months. Any issues identified will be corrected immediately. Any concern from the resident will be reported per regulation requirement. Any alleged team member will be suspended immediately pending investigation. Random interviews by the NHA, DON, & ADON will be audited for 6 months or until 100% compliance is achieved and findings will be discussed in monthly QAPI. The findings include: 1) The facility reported incident #MD00182604 was reviewed by the surveyor on 1/9/25 at 11:30 AM. The facility substantiated through witnesses (Licensed Practical Nurse) LPN3 and (Geriatric Nursing Assistant) GNA6 that GNA7 physically assaulted Resident #905 at approximately 11:30 PM on 4/25/22. The report revealed that the incident was not reported to the DON until 4/26/22 at 6:03 PM by LPN3. Review of the facility ' s investigation documentation on 1/9/25 at 12:00 PM revealed a written statement by LPN3 dated 4/26/22. LPN3 indicated that at the change of shift on 4/25/22 Resident #905 was attempting to pull at the kitchen door because s/he thought it was the bathroom. LPN3 and GNA6 ' s attempts to redirect the resident were unsuccessful. GNA7 came over, grabbed Resident #905 by the back of his/her shirt and spun him/her around in the wheelchair and began to choke him/her. LPN3 indicated she stepped in between them and told GNA7 to calm down. She indicated that Resident #905 was sitting in the corner by the TV and was upset and yelling so GNA7 charged over and punched him/her in the stomach. Resident #905 was threatening to report GNA7 so GNA7 got mad and pulled him/her by the back of his/her hair and spun him/her around in the wheelchair until he/she was back in the corner. LPN3 indicated that she kept pulling GNA7 away to diffuse the situation, but she kept coming for Resident #905. LPN3 finally yelled at GNA7 and pushed her away and she went into the lounge area. LPN3 indicated she kept Resident #905 up front at the nurse ' s station with her all night and GNA6 was the residents GNA and provided care for Resident #905. In a written witness report dated Monday April 25th, 2022, GNA6 indicated that approximately 11:30 PM an altercation occurred between GNA7 and a resident. The resident was attempting to enter the locked kitchen while yelling s/he needed the bathroom. I, GNA6, went up to attempt to convince him/her to go to his/her room where the bathroom was. After a couple of minutes, the nurse came to convince him/her as well. GNA7 intervened, seeing the situation still unresolved. She pulled his/her hands off the door handle and yanked on his/her shirt ' s neckhole to pull him/her backwards. She moved him/her back to the corner with the TV. At this point I backed away letting the nurse handle it. The only other thing I saw after was the resident swatting at GNA7 and GNA7 raising her arm as though to threaten hitting him/her back. GNA7 ' s written statement indicated she was down the hall and heard Resident #905 screaming and hollering. S/he was at the kitchen door. GNA7 pulled him/her back from the door and told him/her that he/she could not go home that way. Resident #905 continued to scream and was hitting. LPN3 told him/her not to do that. GNA7 indicated the reason why she went to Resident #905 was because sometimes she can redirect him/her. That she didn ' t want Resident #905 to wake up the other residents and that she left him/her in the hall and walked away from him/her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Written follow-up interviews were conducted by the Regional HR (Human Resources) Director and the DON on 4/27/22 with GNA6, LPN3 and GNA7. GNA6 indicated during her interview that she did not report the incident because the nurse stated she was going to. The Regional HR Director and DON did not ask LPN 3 why she did not report the abuse immediately. The surveyor called LPN3 for an interview on 1/13/25 at 9:00 AM. The call went to voicemail, and a message was left asking for her to return the call. LPN3 did not return the surveyor's call prior to the end of the survey. The time punch records for GNA7 were reviewed on 1/9/25 at approximately 4:00 PM. The punches revealed GNA7 worked from 3:00 PM on 4/25/22 until 7:51 AM on 4/26/22. She worked again on 4/26/22 from 2:57 PM until 7:01 PM. The facility staff failed to protect residents from abuse by allowing GNA7 to work 12 additional hours in the facility after witnessed abuse of Resident #905. In an interview on 1/9/25 at 4:30 PM the DON confirmed that GNA7 was not suspended until after she became aware of the incident at 6:03 PM on 4/26/22. She indicated that GNA6 did not report the incident. In an interview on 1/10/25 at approximately 9:30 AM the DON was asked to provide verification of abuse training for LPN3. She explained she was agency staff; we don ' t have her abuse training. The agency provides us with their license, background checks, the things that are required in Maryland, but we don ' t get their abuse training. The facility failed to ensure that all staff working in their facility had the required training for abuse and abuse prohibition. The DON was asked and indicated that a Root Cause Analysis was not done for this event. When asked if the Quality Assessment Performance Improvement (QAPI) committee reviewed and investigated the root cause, she indicated we discussed it but as far as documentation there is only the investigation I gave you. The facility failed to implement a QAPI process to address the incident and lack of immediate response. Review of GNA7 ' s employee file failed to reveal performance evaluations after 2011. The DON was made aware of this finding on 1/13/25 at 10:35 AM. She indicated that when she first came to the facility as the DON it was July 2020, during COVID, she did not do evaluations. When asked when she started doing the performance evaluations again, she paused then stated I only do evaluations of my ADON (Assistant Director of Nursing). On 1/13/25 at 1:30 PM when asked to further clarify who does performance evaluations for the other nursing staff the DON stated, they ' re not done. 2) Facility reported incident #MD00185366 was reviewed on 1/8/25 at 10:15 AM. The facility report indicated: on 1/11/22 a family member reported Resident #901 alleged that the previous morning s/he called an employee a bitch and the employee smacked him/her on the mouth and told him/her not to call her names. The DON interviewed the resident who did not recall an altercation with staff nor remember the conversation with his/her family member 30 minutes prior. No injuries were noted. The DON interviewed multiple employees that worked on the unit over the 4 days leading up to the event. There were no reports to corroborate the family member ' s concern. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The report contained no evidence that the abuse allegation was reported to the police. The facility ' s investigation documentation included a written statement from Resident #901 ' s family member, dated 10/31/22. The statement revealed that the resident indicated s/he needed to move due to people problems. That the perpetrator accused the resident of calling her a bitch and slapped him/her. The statement also indicated that Resident #901 did not want the family member to say anything for fear of retaliation. The statement did not indicate a date of the alleged incident. The investigation included statements from 5 staff members: GNA8 ' s statement dated 11/2/22 indicated she saw another resident touch Resident #901 on 10/28/22 at 6 AM. They were redirected. GNA9 ' s statement dated 11/4/22 indicated she cared for Resident #901 7AM - 9PM on 10/29/22 and 7AM - 3PM on 10/30/22. There were no concerns. GNA1 ' s statement dated 11/4/22 indicated she didn ' t notice anything different with Resident #901 or staff on 11/29/22 and 11/30/22. GNA5 indicated in her statement dated 11/1/22 that she had not heard or had any situations or problems with Resident #901. Had never heard him/her cuss or fuss about anything. An undated statement written by GNA10 indicated that while assisting Resident #901 to bed at 7:30 PM on October 28th. He/She mentioned to me, about being slapped in the face, during the day by someone in the T. V. Room. Two times in the face. I meant to report it but forgot due to a busy night. Sorry! GNA10 failed to immediately report an allegation of abuse. There was no evidence the facility acted on the additional allegation of abuse after it was brought to their attention in GNA10 ' s written statement. Staff schedules revealed 26 staff worked on the unit where Resident #901 resided between 10/28/22 and 10/30/22. The facility ' s investigation did not include statements from 21 staff who worked during that time. During an interview on 1/9/25 at 10:31 AM the DON confirmed that the police were not notified of the allegation of abuse and she was not able to recall why. She was asked if she expanded her investigation once she received GNA10 ' s staff statement. She confirmed she was aware of the statement and that once she saw the statement was not sure why she wouldn ' t have gotten more statements. During an earlier interview conducted on 1/8/25 at approximately 7:35 AM when asked who the facility ' s abuse coordinator was, the DON responded - I guess I am because I ' m the DON. 40902 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3.) During an interview on 01/07/25 at 11:25 AM R45 stated that GNA1 hates him/her just because s/he is him/her. R45 said GNA1 mouths off to him/her and when s/he reports something about GNA1 to administration, GNA1 gets even with him/her by reporting something false about him/her. R45 stated that GNA1 killed his/her dog. R45 stated that GNA1 ignores her job duties and called him/her a bitch. S/he said s/he reported it to the DON who told R45 that GNA1 ' s behavior was unacceptable. R45 said GNA1 and GNA2 would gang up on him/her and talk about him/her in the hall because s/he could hear them. On 01/07/25 at 11:45 AM, R45 ' s allegations of verbal and mental abuse were reported to the Administrator and the DON by the surveyor. An interview on 01/08/25 at 12:27 PM the DON and Administrator revealed that they do not believe R45 and that GNA1 was allowed to continue working the 7am to 3pm shift on 01/07/25. Interview with the Corporate nurse on 01/08/25 stated that staff are to be suspended while the facility is investigating allegations of abuse. Review of the Abuse policy dated 07/2023 revealed after an allegation of abuse was made they would immediately protect the resident from further risk. Review of R45 ' s Face Sheet revealed the resident was admitted to the facility on [DATE]. Review of R45 ' s Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/24 and located in the resident ' s EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated no cognitive impairment. During an interview on 01/08/25 at 12:27 PM the DON stated that she had a discussion with the Administrator after they became aware of R45 ' s allegations on 01/07/25 and that nothing had happened because she was waiting to discuss it with the Regional Clinical Nurse. During an interview on 01/08/25 at 12:42 PM the Administrator stated that he consulted with the DON and Medical Director. He said that they decided there was no validity to R45 ' s allegations based on the fact that s/he never had a dog here, and that GNA2 has not worked here for a long time. The Administrator stated that he did not interview the resident or any staff before making this conclusion. He stated that when he does conduct an investigation, he will interview the resident and any staff that have been identified. He stated that he did not investigate the allegation, and that GNA1 was not suspended.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on medical record review, review of facility reported incidents and interview with facility staff, it was determined that the facility administration failed to report all reportable incidents to the Office of Health Care Quality (OHCQ) no later than 2 hours after alleged abuse incidents occurred and/or injuries of unknown origin meeting the regulatory criteria. This was evident for 7 (#903, #902, #904, #901, #905, R45,and R211) of 12 residents reviewed for abuse with additional occurrences found during the individual review of the resident's medical records that too were not reported to the state agency, and failed to report an allegation of abuse to local law enforcement for 1 (#901) of 9 residents reviewed for abuse. The findings include: 1. Review of the medical record for Resident #903 on 1/10/25 at 7:47 AM revealed diagnosis including Alzheimer's and age-related osteoporosis. Review of a facility reported incident (FRI) completed and submitted on 5/11/24 at 8:40 AM, Resident #903 was documented as having an unwitnessed fall which resulted in a left intertrochanteric fracture. This incident was documented as occurring on 5/10/24 at 9:45 PM, approximately 10 hours prior to the initial submission of the FRI to the Office of Health Care Quality. This identified concern was reviewed with the DON and NHA during the survey and again on 1/13/25 prior to exit. 2. Review of the medical record for Resident #902 revealed initial admitting diagnosis including breast cancer, dysphagia (difficulty swallowing) and dementia. A review on 1/7/25 at 2:00 PM during the review of the progress notes, revealed multiple incidents of documented injuries of unknown origin and identified bruising that were not reported to the OHCQ, as confirmed by the DON on 1/8/25 at 7:35 AM and verified by the OHCQ intake department. a. 12/30/22 bruise to inner thigh newly identified, medium sized b. 2/12/23 bruise to left lateral brow c. 3/11/23 unwitnessed fall, with intervention noted that the unit is on isolation just continue to monitor (4th fall noted with no new interventions) d. 8/19/23 pain on right leg, bruising noted to right cheek, an x-ray was ordered to rule out fracture. These concerns were reviewed with the facility DON and NHA throughout the survey and again on 1/13/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #904 on 1/8/25 at 7:53 AM revealed multiple comorbidities including dementia and Parkinson disease. During the review of a reported FRI, another incident was noted to occur on 3/15/23 where Resident #904 was found on the floor complaining of pain and was transferred to the emergency room for the treatment of a fracture. There was no report to the OHCQ regarding the identified fall and subsequent fracture. By day 5, the injury was determined to be an old fracture, however, within what would have been the initial 2-hour reporting time frame, Resident #904, who had a documented BIMS of 4, assessed on 3/22/23, was unable to report what had occurred on 3/15/23. These concerns were reviewed with the facility Regional Clinical Nurse on 1/9/25 at approximately 3:30 PM and again with the facility DON and NHA on 1/13/25. cross reference F610, F835 31982 4. Facility reported incident #MD00185366 was reviewed on 1/8/25 at 10:15 AM. The facility reported that Resident #901 told his/her daughter on 11/1/22 that the previous morning he/she called an employee a bitch and the employee smacked him/her on the mouth and told him/her not to call her names. The Director of Nursing (DON) reported the incident to the state agency and began an investigation. There was no evidence that the allegation of abuse was reported to local law enforcement. The investigative documentation included 5 statements written by staff who worked with resident #901 on or around the date of the alleged event. An undated statement by GNA (Geriatric Nursing Assistant) #10 indicated on Friday October 28th - Resident #901 mentioned that s/he was slapped twice on the face during the day by someone in the TV room, but GNA #10 forgot to report it. These and other findings were discussed with the DON during an interview on 1/9/25 at 10:31 AM. She confirmed that the police were not notified of the abuse allegation and that she was aware of that GNA#10 failed to report Resident #901's allegation of abuse made on 10/28/22. 5. Facility reported incident #MD00182604 was reviewed on 1/9/25 11:30 AM. The report indicated that GNA#7 was observed pulling Resident #905 by his/her collar, pull his/her hair, grab him/her by the neck and punch him/her in the abdomen at approximately 11:30 PM on 4/25/22. Per written statements, the incident was witnessed by LPN (Licensed Practical Nurse) #3, an agency nurse. GNA#6 was also present and per her statement witnessed some of the incident. The facility's investigation documentation revealed the incident was reported to the DON by LPN#3 at 6:03 PM on 4/26/22, 18 1/2 hours later, not immediately. GNA#6 indicated in her written statement that she did not report the incident because she thought LPN#3 reported it. In an interview on 1/9/25 at 4:30 PM The DON confirmed that neither LPN#3 nor GNA#6 immediately reported the incident and that she was not aware until 6:03 PM the following day. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/14/25 at 3:21 PM GNA#6 repeatedly indicated she was unable to recall details of the incident. She was unable to recall why she thought LPN#3 was going to report the incident. She did recall that LPN#3 made a phone call but was unsure of who she called, and stated it could have been about anything. Cross reference F 600 and F 835. 40902 Review of the facility's policy titled Abuse, Neglect, Involuntary seclusion, Exploitation, and Misappropriation of Property revised 07/23 revealed, anyone who witnesses and or suspects an incident of resident abuse (verbal, sexual, mental, or physical), neglect, mistreatment, exploitation' involuntary seclusion, and misappropriation of property or a crime must immediately report the incident to their department supervisor. The department supervisor must immediately notify the executive director's administrator or designee, who in turn will notify the regional director of nursing, who in turn will notify the corporate director of resident health services and human resources, if necessary. Notify the appropriate state agency, adult protective services where state law provides for jurisdiction, and local law enforcement for a crime or allegation of a crime, immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or suspicion or actual commission of a crime, or not later than 24 hours if the events that cause the allegation do not involve abuse, a crime, and/or do not result in serious bodily injury, in accordance with state law through established procedures. Criminal acts include, but are not limited to, assault, sexual assault, and theft of resident property, including medications. 6. Review of R45's Face Sheet located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included Major Depressive Disorder, Mild Cognitive Impairment, Hallucinations, Unspecified Dementia, and anxiety disorder. Review of R45's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/24 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated no cognitive impairment. Further review revealed no behaviors were indicated. During an interview on 01/07/25 at 11:25 AM, R45 said Geriatric Nurse Assistant (GNA)1 hated him/her just because s/he is him/her. R45 said GNA1 mouths off to him/her and when s/he reports something about GNA1 to administration GNA1 gets even with him/her by reporting something false about R45. R45 said s/he believed she killed his/her dog, and that GNA1 ignores her job duties. R45 said GNA1 called him/her an (expletive). S/he said s/he reported it to the Director of Nursing (DON) who told R45 that it was unacceptable behavior. S/he said GNA1 was still currently employed. S/he said the last time she gave R45 a shower s/he was afraid that GNA1 did not wash his/her body well or dry him/her off properly. R45 said GNA1 did not care about the care she provided to him/her. R45 said GNA1 and GNA2 would gang up on him/her and talk about him/her in the hall because s/he could hear them. S/he said they said they were not going to do the right thing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 12:27 PM the DON stated she had a discussion with the Administrator after they became aware of the allegations by R45 but that was as far as it's gone. She stated they have not reported it to the state and that she was waiting to discuss it with Regional Clinical Nurse. The DON further stated she did not know why she did not report the allegation that LPN1 reported to her about GNA1 and R211, but she stated she should have reported both timely. During an interview on 01/08/25 at 12:42 PM the Administrator consulted with the DON, and he spoke to the Medical Director. He said that they decided there was no validity to the allegation based on the fact that she never had a dog here, and that GNA2 has not worked here for a long time. He confirmed this was not reported to the state and that he did not interview the resident or any staff before making this conclusion. 7. Review of R211's "Admission Record," located in the "Profile" tab of the EMR, revealed R211 admitted to the facility on [DATE] with diagnoses including bipolar disorder, adjustment disorder, and dysphagia. Review of R211's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 03/01/23 revealed s/he scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. Review of the Self-Report Form provided by the facility, dated 05/01/23 at 2:00 PM revealed the date and time of the incident was 04/28/23 between the 11 PM to 7 AM shift.

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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** 30428 Based on medical record review and interview with facility staff, it was determined that the facility staff failed to thoroughly investigate allegations of abuse and injuries of unknown origin, and failed to protect residents from further abuse. This was evident for 7 (#902, #903, #904, #901, #905, R45, and R45) of 12 residents reviewed for abuse with additional occurrences found during the individual review of the resident's medical records that were not previously identified by the facility. The findings include: 1. Review of the medical record for Resident #902 revealed initial admitting diagnosis including breast cancer, dysphagia (difficulty swallowing) and dementia. A review on 1/7/25 at 2:00 PM an initial concern related to an unwitnessed fall, occurring on 7/12/23. According to the facility investigation report, the resident was found on his/her back and bleeding from their left forehead. There was a black and blue bump already formed when the resident was found. Resident #902 complained of left shoulder and elbow pain and had difficulty moving their arm without grimacing. An x-ray was ordered. Resident #902 was transferred to the hospital on 7/13/23 for treatment related to a nondisplaced olecranon (elbow fracture). Further review of the facility reported incident on 1/10/25 at 7:23 AM failed to reveal any interviews with more than just the GNA that was assigned to care for Resident #902 on 7/12/23. Additionally, there was no new interventions or plan in place to prevent Resident #902 from falling again. 2. Review of the facility reported incident on 1/10/25 at 7:47 AM for Resident #903 noted admission diagnosis including unspecified dementia and abnormalities of gait. According to the facility reported paperwork provided to the survey team, Resident #903 had an unwitnessed fall with injury occurring on 5/10/24 documented between 9:45 PM and 10:15 PM. Resident #903 was sent to the hospital post fall with complaints of hip and lag pain. A CT (computed tomography scan, is a noninvasive medical imaging procedure that uses X-rays to create detailed pictures of the inside of the body) was completed and diagnosed Resident #903 with a left intra trochanteric fracture-hip fracture. According to the facility investigation packet, only the nurse and GNA caring for the resident were interviewed regarding his/her status prior to the fall. There was an identified concern with the bed alarm, however, no further documentation of interventions or audits to ensure that what was found faulty and possibly contributing to the resident's fall was corrected. These concerns were reviewed with the facility DON and NHA throughout the survey and again on 1/13/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. a. Review of the medical record for Resident #904 on 1/8/25 at 7:53 AM revealed multiple comorbidities including dementia nd Parkinson disease. Review of the facility reported incident for Resident #904 revealed that Resident was found on the floor on 5/30/23 with a hematoma on their forehead and scant blood noted on their mouth and nose. An order was acquired from the physician to send him/her to the ER for evaluation. At the hospital it was determined that the resident had a left orbital floor fracture, and a mild fracture of the left anterior maxillary wall. Additionally, a left subdural hematoma (a collection of blood between the brain and the skull that can be life-threatening). The facility investigation report failed to include any interviews with staff or residents from the day of the incident. The report documented that the resident was unable to state what occurred and it was assumed that the resident fell out of his/her chair and hit their face causing the fractures. b. During the review of the assumed fall on 5/30/23 for Resident #904, another unwitnessed fall was identified with an initially identified fracture on 3/15/23. This was not investigated with corresponding interviews of staff and residents with subsequent relevant interventions. These concerns were reviewed with the facility Regional Clinical Nurse on 1/9/25 at approximately 3:30 PM and again with the facility DON and NHA on 1/13/25. Cross reference with F609 31982 4. Facility reported incident #MD00185366 was reviewed on 1/8/25 at 10:15 AM. The facility reported that on 10/31/22, Resident #901, a resident with severe cognitive impairment, reported to his/her daughter that the previous morning he/she called an employee a bitch and the employee smacked him/her on the mouth and told him/her not to call her names. The Director of Nursing (DON) reported the incident to the state agency and began an investigation. Written statements were obtained from 5 staff. The statement written by GNA (Geriatric Nursing Assistant) #10 revealed that Resident #901 reported to her on 10/28 that s/he was slapped twice on the face during the day by someone in the TV room, but she forgot to report it. The documentation failed to reveal that the facility expanded or began a new investigation after they became aware of the earlier abuse allegation in Staff #10's statement. Staffing schedules revealed that 26 nursing staff worked on the unit where Resident #901 resided from 10/28/22 - 10/30/22. However, written statements were only obtained from 5 nursing staff. There were no statements from non-nursing staff including but not limited to activities, maintenance, laundry, dietary or housekeeping personnel, in an effort to collect information potentially useful to their investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Facility reported incident #MD00182604 was reviewed on 1/9/25 11:30 AM. The report indicated that on 4/25/22 at approximately 11:30 PM, GNA#7 pulled Resident #905, a wheelchair bound resident, by his/her collar, pulled his/her hair, grabbed him/her by the neck, rushed at the resident and punched him/her in the abdomen. Per her written statement, LPN (Licensed Practical Nurse) #3 witnessed the event. GNA#6 was also present during part of the incident and, per her statement, witnessed some of the same events. GNA#7's time punch records were reviewed on 1/9/25 at approximately 4:00 PM. They revealed that GNA#7 continued to work approximately 8 hours and 20 minutes, from 11:30 PM on 4/25/22 until 7:51 AM on 4/26/22. She returned at 2:57 PM on 4/26/22 and worked an additional 3 hours until sent off duty at 6:03 PM by the DON. During an interview on 1/9/25 at 4:30 PM the DON was asked to clarify when GNA#7 was suspended after the incident. She indicated that when she came in to work the next day 4/26/22, she was made aware of the incident, she informed the nurse on duty to obtain a statement from GNA#7 and send her home pending the outcome of the investigation. She confirmed that GNA#7 was not sent off duty on 4/25/22 immediately after the incident. When asked why, she indicated that GNA#6 did not report the incident and LPN#3 was an agency staff member and did not report it immediately. The facility failed to protect the residents by failing to ensure that GNA#7 was removed from the facility pending the outcome of the abuse allegation. Cross reference F 600. 43050 Review of a policy provided by the facility titled Abuse, Neglect, Involuntary Seclusion, Exploitation, and Misappropriation of Property Prevention, dated 07/2023 indicated . The investigative summary report must include sufficient detail to document the facility conducted a thorough investigation and shall include: Date and time of the alleged incident; Resident's full name and room number; Details of the allegation and any injury; Name(s) of the accused and any witnesses; Name of the facility staff member(s) who investigated the allegation; Any corrective action taken by the facility (i.e., disciplinary actions, staff training, etc.); The results of the investigation (i.e., was the allegation substantiated or unsubstantiated). 1. Review of the undated Admission Record in the electronic medical record (EMR) under the Profile tab revealed R24 was admitted to the facility on [DATE] with diagnoses which included dementia and major depressive disorder. 6. Review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/13/24 in the EMR under the MDS tab revealed R24 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of zero out of 15. Review of the facility investigation provided by the facility for an injury of unknown origin, revealed R24 had a bruise on the face with no known fall. Progress note dated 08/22/24 at 7:34 AM stated, Resident noted to have bruise 6x4 on left side of face by eye which was noted at shift change. Left eye puffy. Resident in no distress. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/25 at 7:35 AM with Geriatric Nurse Assistant (GNA) 4 on revealed I took care of the resident during the 11-7 shift and no incident occurred. I do not know how she received the bruise. During an interview with the Director of Nursing (DON) who completed the investigation revealed, This was an injury of unknown origin. R24 had bruising to the left side of her face. A complete skin assessment was not done. The entire body should have been assessed since it was an injury of unknown origin. When asked if R24 hit her head, the DON did not know. When the DON was asked if other residents were interviewed or all staff that had been working during the night shift, the DON stated No other residents were interviewed or staff. This was an incomplete investigation. 7. Review of R45's Face Sheet located in resident's EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included Major Depressive Disorder, Mild Cognitive Impairment, Hallucinations, Unspecified Dementia, and anxiety disorder. Review of R45's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/24 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated no cognitive impairment. Further review revealed no behaviors were indicated. Review of R45's Care Plan, dated 11/30/22 and located in the residents' EMR under the Care Plan tab, revealed I use psychotropic medications related to depression, anxiety, insomnia, dementia (I have hallucinations, delusions/paranoia at times). Interventions in place were Resident continues with hallucinations and delusions/paranoia at times. Resident re-directed and re-oriented to reality when having those episodes. Mood does appear improved 05/22/24. Further interview revealed no care plan related to making false allegations. During an interview on 01/07/25 at 11:25 AM, R45 said Geriatric Nursing Assistant (GNA)1 hates him/her just because s/he is him/her. R45 said GNA1 mouths off to him/her and when s/he reports something about GNA1 to administration GNA1 gets even with him/her by reporting something false about R45. R45 said s/he believed she killed his/her dog, and that GNA1 ignores her job duties. R45 said GNA1 called him/her an (expletive). S/he said s/he reported it to the DON who told R45 that it was unacceptable behavior. S/he said GNA1 was still currently employed. R45 said GNA1 did not care about the care she provided to him/her. R45 said GNA1 and GNA2 would gang up on him/her and talk about him/her in the hall because s/he could hear them. S/he said they said they were not going to do the right thing. During an interview on 01/07/25 at 11:45 AM the allegations by R45 about GNA1 were reported to the Administrator and the DON. The DON stated she was aware of the allegations about the dog, but this was the first time she heard that R45 alleged that GNA1 called him/her an (expletive). The DON said this was never reported and that R45 has never had a dog on the facility grounds. During an interview on 01/08/25 at 12:27 PM the DON she had a discussion with the Administrator after they became aware of the allegations by R45 but that was as far as it's gone. She stated they have reported it to the state and that she was waiting to discuss it with Regional Clinical Nurse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 12:42 PM the Administrator consulted with the DON, and he spoke to the Medical Director. He said that they decided there was no validity to the allegation based on the fact that s/he never had a dog here, and that GNA2 has not worked here for a long time. He said this was not reported to the state and that he did not interview the resident or any staff before making this conclusion. He stated after an allegation is made they decide if it's valid before they report it to the state. If they investigate they will interview the resident and any staff that was identified and that any staff who was named as an alleged perpetrator would be suspended during the investigation. He stated that he did not investigate the allegation, and the staff was not suspended.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on interview, record review, and policy review, the facility failed to ensure one resident (Resident (R)52) of two residents reviewed for falls out of a total sample of 27 residents had root cause analysis and a thorough investigation completed to determine if additional interventions were warranted when the resident had 11 falls, one resulting in harm when the resident sustained a left hip fracture requiring surgery. This had the potential for the resident to continue to have falls with possible major injuries. Findings include: Review of the facilities revised November 2020 Fall Reduction and Management Policy revealed Strive to identify residents at risk for falls and reduce the incidence of falls by identifying environmental, interpersonal, and/or functional triggers and causes of fall and implementing person-centered interventions to reduce risks. To strive to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision, functional support, and assistance devices to prevent and/or minimize accidents. Recommendations for prevention of future occurrences will be incorporated into the resident's care plan. Review of R52's Electronic Medical Record (EMR) under the Census tab revealed the resident was admitted to the facility on [DATE]. Review of R52's diagnoses located in the EMR under the Diagnosis tab revealed a diagnosis of Alzheimer's Dementia. Review R52's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an assessment reference date (ARD) of 10/15/24 Brief Interview for Mental Status (BIMS) of five out of 15, which showed s/he had severe cognitive impairment. The MDS showed the resident required limited assistance of one staff for transfers, toileting, and ambulation. Review of R52's Care Plan located under the Care Plan tab a fall focus area revealed I am a fall risk r/t [related to] deconditioning, Gait/balance problems, Incontinence, Unaware of safety needs, Alzheimer's/Dementia started on 09/22/23. A goal revealed I will be free of minor injuries started on 09/22/23. Interventions started after 09/22/23 included Encourage me to participate in activities that promote exercise, physical activity for strengthening and improved mobility started on 07/09/24 and Call bell pad to alert nursing of movement and to reduce the risk of falls initiated on 12/11/24. There were no new interventions added to potentially prevent further falls from 09/22/23 until 07/09/24. Review of R52's EMR Progress Notes located under the Progress Notes tab revealed he had at total of 11 falls; on 10/20/23, 10/28/23, 11/25/23, 01/01/24, 01/04/24 (two falls), 03/30/24, 05/20/24 (two falls), 06/27/24, and 07/01/24. The fall on 07/01/24 resulted in a fracture to his left hip. Review of R52's Progress Notes located in the EMR under the Progress Note tab revealed the following falls: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. Details of a fall on 10/20/23 at 10:40 PM revealed an Aide went into the resident's room to pick up his/her dinner tray. She found him/her on his/her knees next to the bed. Fall mats were down and s/he was actually kneeling on the fall mat. Resident said s/he was trying to get to his/her desk to get some toothpicks. 2. Details of a fall on 10/28/23 revealed the resident was found on the fall mat kneeling next to his/her bed. S/he had the upper part of his/her body resting on the bed. S/he was unable to tell staff what s/he was trying to do. S/he did not have any c/o pain or discomfort. His/her skin is intact with no bruising or skin tears noted 3. Details of a fall on 11/25/23 revealed the resident's family hired aide had called staff to the room. When staff arrived in the room the resident was sitting on the floor in front of his/her recliner. The aide said the resident told her s/he could walk so she had attempted to transfer the resident from his/her bed to the recliner and s/he landed on the floor. No injuries were noted. Caregiver was made aware that the resident required a hoyer lift for transfers and when needing assistance to please notify staff. 4. Details of a fall on 01/01/24 revealed the resident was observed lying on his back in his/her bathroom beside his/her wheelchair. Resident attempted to transfer to the toilet without calling for assistance. Resident obtained a skin tear to his/her left forearm. No other injuries were noted. 5. Details of a fall on 01/04/24 revealed the resident was found on the floor. S/he was on the floor next to his/her bed lying on his/her back. His/her head was at the end of the bed where the footboard was. S/he had a skin tear on the resident's lower left extremity. S/he denied any pain or discomfort. 6. Details of the second fall on 01/04/24 revealed the resident was heard calling from his/her room. S/he was found lying on his/her left side in front of the recliner. S/he could not tell us why s/he had gotten out of bed. S/he had no complaints of pain or discomfort. No new skin issues. Resident reminded to use call bell if s/he needs to get out of bed. 7. Details of a fall on 03/30/24 revealed the resident was observed sitting on the floor beside his/her bed near his/her recliner. Resident was attempting to transfer out of bed to his/her recliner without assistance. Resident obtained a skin tear to his/her lower left leg and right elbow. 8. Details of a fall on 05/20/24 revealed A Geriatric Nursing Assistant (GNA) found the resident lying on his back on the floor mat next to bed. Resident has no injuries noted. The resident participated in therapy. 9. Details of a second fall on 05/20/24 revealed the resident was observed sitting on his/her buttocks in front of his/her recliner. Resident was attempting to transfer without calling for assistance to his/her wheelchair. No injuries noted. 10. Details of a fall on 06/27/24 revealed the resident was found on floor in the resident's room, lying on his/her left side. A skin tear was noted to the left hand. Resident was alert, awake and oriented to baseline. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	11. Details of a fall on 07/01/24 revealed the resident was observed lying on his/her back in his/her bathroom beside his/her wheelchair. Resident attempted to transfer to the toilet without calling for assistance. Resident obtained a skin tear to his/her left forearm. Resident denied hitting his/her head. No other injuries noted. The resident was escorted out to the common area after having dinner in the dining area. The resident complained of pain in the upper left leg. Tylenol given for pain. [physician] notified of c/o pain. An x-ray was ordered. The x-ray indicated the resident had a fracture of his/her left hip and had a left hemiarthroplasty (surgery). Review of R52's Fall Risk Evaluations completed on 09/21/23, 12/22/23, 12/28/23, 03/28/24, 07/09/24, 07/30/24, and 10/30/24 revealed scores had been based on level of consciousness/mental status, history of falls in the past three months, ambulation/elimination, vision, gait/balance, systolic blood pressure, medications, and disease processes. His/her scores indicated s/he was at high risk for falls. Review of R52's Fall Incident Reports completed after each fall and provided by the facility included a review of the residents' diagnoses, medications including psychoactive, anticoagulants, steroids, antihypertensives, and new medications in the last seven days. Any changes in mental status, unsteady gait, combative or agitated, continent, or incontinent. Other areas reviewed including what type of equipment the resident used, if their call light was near or on, footwear, use of a walker/cane/wheelchair, use of a bed or chair alarm, use of side rails, and the condition of the room. Those areas were filled out however, under the Fall Huddle Investigation Worksheet that was completed with staff working at the time of the falls revealed there were no new interventions listed other than monitoring. The Root Cause of Fall section had not been completed for any of the falls. During an interview on 01/10/25 at 1:30 PM with the Director of Nursing (DON) confirmed the Fall Intervention Form only had monitoring as the intervention. She also agreed the Root Cause of Fall section had not been completed, and it could have brought more ideas for effective fall prevention interventions.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 30428 Based on medical record review and interview with facility staff, and after the review of multiple facility reported incidents, it was determined that the facility failed to administer and document pain medication for residents with reported pain. This was evident during the review of 2 of 3 residents with reported falls and pain. (#903 and #902) The findings include: 1. Review of the medical record on 1/10/25 at 7:47 AM for Resident #903 noted admission diagnosis including unspecified dementia and abnormalities of gait. Resident #903 was assessed on 12/19/23 as having a brief interview of mental status (BIMS) of 5, meaning that s/he had severe cognitive impairment. Nursing progress notes documented that s/he would ambulate with either a walker or wheelchair throughout the unit. During the review of a facility reported incident (FRI) occurring on 5/10/24, Resident #903 was documented that s/he was found on the bathroom floor and had complaints of left hip pain. Nursing documented that Tylenol was administered at 9:50 PM for the pain. A concurrent review of the resident's medication administration record (MAR) failed to reveal that any Tylenol was administered, though the residents' pain was documented as a '6' prior to the resident's transfer to the hospital. . 2. Review of the facility reported incident on 1/10/25 at 7:47 AM for Resident #902 noted admission diagnosis including unspecified dementia and abnormalities of gait. Resident #902 was found on their back in their room on 7/12/23, nursing progress notes and corresponding MAR documented that the resident was medicated with Tylenol. On 7/12/23 at 11:15 PM nursing documented that Resident #902's arm was swollen, and s/he was unable to straighten arm and reports pain to elbow when touched. According to the corresponding MAR reviewed on 1/14/25 at 9:00 AM, no further Tylenol was administered, though the physician order was for every 6 hours as needed, and Resident #902 was complaining of pain. Resident #902 had an x-ray completed and was diagnosed with an Olecranon (elbow) fracture. On 7/15, 7/16, 7/17 and 7/18, nursing progress notes all documented that Resident #902 had complaints of pain on the left arm and was given routine Tylenol. However, concurrent review of the MAR failed to reveal that any Tylenol was administered except one time on 7/17. The progress notes all repeated the same information verbatim. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern that the resident was not medicated for pain, or was not appropriately and thoroughly assessed was reviewed with the facility DON and NHA on 1/13/25. b. Resident #902 also had a noted injury on 8/19/23 according to nursing progress notes, reviewed on 1/14/25. At 5:14 AM, nursing documented that the resident complained of pain in the upper part of the right leg and had a bruise on [his/her] right cheek. However, according to the MAR, no Tylenol or any pain medication was signed off until 3:58 PM that afternoon. This concern was reviewed with the facility DON on 1/13/25. RN#4 was interviewed on 1/14/25 at 11:15 AM. She was asked how she assesses a resident's pain. She reviewed the process according to the facility policy and confirmed that there are different assessments for residents on different cognitive levels and that are unable to state pain on a 1-10 pain scale. Those assessments include looking at the residents for physical signs of pain such as grimacing and not solely relying on a numerical scale. She also stated that that information gets documented at that time and progress notes are never copied over from the day prior.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 31982 Based on review of staff records and interview with facility staff, it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) received a performance review at least once every 12 months. This was evident for all GNA's working in the facility since 2022 and has the potential to affect all residents. Failure to perform performance reviews prevents the facility from providing regular in-service education that is based on the outcome of these reviews. The evidence includes: The employee file of GNA#7 was reviewed on 1/13/25 at 9:30 AM, during review of a facility reported incident (#MD00182604) related to abuse. No performance reviews were found in the file. Upon request, the Director of Nursing (DON) provided the last 3 reviews for GNA#7 which were dated 1/27/09, 9/4/09 and 10/26/11. On 1/13/25 at 10:35 AM the DON was informed that the documentation she provided did not contain performance evaluations after 2011. She indicated that she came to the facility as the DON in 2020 during COVID, and she did not do evaluations. She was asked when she began doing performance evaluations again. She paused then stated: I only do evaluations of my ADON (Assistant Director of Nursing). On 1/13/25 at 1:30 PM The DON was asked to clarify who was responsible for completing the performance evaluations for the other nursing staff. She stated, they're not done.

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	215137	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrooke CT Skilled Care Ctr at Bayleigh Chase	501 Dutchman's Lane Easton, MD 21601

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 30428 Based on staff interview and medical record review, it was determined that the facility administration failed to provide effective oversight activities for the facility to ensure that resources were used effectively to meet the health and safety needs of each resident and identify and correct inappropriate care processes/standards, as evidenced by 1. Failure to have a system in place to effectively complete investigations related to injuries of unknown origin, 2. Failure to address abuse and further identify/address potential/alleged abusers, and 3. Failure to ensure that all staff received required training for abuse. The administration's failure to ensure processes were in place that could identify and correct deficient practice in care had the potential to adversely affect the health and safety of all the residents in the facility in addition resulted in an immediate jeopardy for abuse related to the failure to identify and address actual abuse of a resident. The findings include: 1. On 1/7/25 at approximately 10:30 AM the survey team provided the Director of Nursing (DON) with a list of facility reported incidents for review and requested the corresponding facility investigations. At 2:00 PM on 1/7/25 the investigations for 2 of 8 of the requested facility reports were provided. The DON was immediately questioned about the investigations as they only consisted of 2 and 3 pages respectively. She stated at that time that the investigations were easy because they knew what had happened. The first report reviewed was for Resident #903, related to an unwitnessed fall that resulted in a fracture, consisted of only 3 pages. The first page was the actual self-report that was submitted to the Office of Health Care Quality (OHCQ) and the next 2 pages consisted of statements from 2 staff. There was no face sheet related to the resident involved in the investigation and no assessment related to the resident at the time of the incident including vital signs and pain assessments. Review of the second intake for Resident #902 that had the same type of occurrence, revealed the same concerns lacking in the investigation packet. The DON was interviewed again on 1/7/25 at approximately 2:20 PM in the presence of the Nursing Home Administrator (NHA). The concern related to the lack of information in the investigation packets was reviewed at that time. The DON stated that she keeps the 'fall' investigations separate. She was then asked to provide the survey teams with everything that she has related to the investigations so the survey can proceed and have it available for review in the morning. On 1/8/25 at around 7:30 AM the DON met this surveyor in the conference room. She provided this surveyor with what the facility calls a 'fall huddle investigation worksheet,' and confirmed that now the investigations were complete. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regarding the investigation for Resident #903, although this occurrence involved a fall, didn't have a fall huddle worksheet completed, just one statement from a witness and now included the resident's physician order set. Surveyor review of the medical record for Resident #903 revealed that there were 5 other incidents from 12/2022 to the present that were not investigated and reported to the OHCQ and therefore, no interventions were reviewed or put in place for the prevention of further injuries. A second review of the combined facility investigations and fall huddle investigation worksheet for the occurrence with Resident #902 revealed that the fall huddle documents what occurred, however, there is no assessment of the resident included or documentation of the acquired injuries of the resident from the occurrence. There was still no witness statements or other interviews related to the occurrences of that day from other staff or residents, and no updates completed on the care plan to show interventions to prevent this incident from occurring again. Resident #904 who was also reviewed for falls and injuries of unknown origin was also found to have had a fall with a fracture that was not reported to the OHCQ and another fall with a fracture that was not thoroughly investigated and therefore no interventions were reviewed or put in place for the prevention of further injuries. On 1/8/25, after initiating the review of the facility investigations, the DON and NHA were interviewed again. They were presented with the investigation packets that the DON had previously presented to the survey team and the concern that they were still lacking key elements of an investigation including assessments and interviews. They were also presented with the other identified falls and injuries found for Resident #903 and #904. The DON did not feel that injuries where they knew the resident fell , even though it was not observed, and a fracture was acquired, needed to be reported. Additionally, injuries such as bruising did not require reporting, however, they were still not internally investigating per the lack of provided documentation. They were asked at that time who was the abuse coordinator and responsible for the final review of the investigations prior to submission. The DON and NHA looked at each other, then the DON stated, I guess me because I am the DON. Interview with the DON on 1/10/25 at 9:24 AM regarding the concerns related to the facility investigations revealed that they do not do root cause analysis' (RCA) for the incidents, aside from the fall huddle investigations, they discuss it but 'as far as documentation that's all they have.' She was asked if they review the residents and put interventions in place. She stated that they review the falls and the entire 'team' which includes nursing and physical therapy review the fall huddle and sign the fall huddle form and decide on corrective actions. On 1/10/25 at approximately 11:00 AM the NHA was notified of concerns related to the investigations and that during the surveyor's review, that there was one staff member that was identified as working with the residents that were identified with bruising and injuries of unknown origin and identified in a recent abuse allegation during this survey that was not suspended upon notification to the DON of that alleged abuse. The concern that the facility was not doing thorough investigations into injuries of unknown origin that they were aware of and looking at RCAs was reviewed at that time. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/10/25 at approximately 11:00 AM the NHA was notified of concerns related to the investigations and that during the surveyor's review, that there was one staff member that was identified as working with the residents that were identified with bruising and injuries of unknown origin that the facility failed to identify. This individual was also identified in an abuse allegation during this survey. The concern that the facility was not doing thorough investigations into injuries of unknown origin that they were aware of and looking at RCAs was reviewed at that time. 2. a. During the survey an abuse allegation against a GNA was made. Upon notification to the DON the employee was not suspended at the time the allegation was made. On 1/13/25 the DON was asked what the process was when someone makes an abuse allegation. She stated to make the resident safe. She was asked why the decision was made not to send the alleged perpetrator home. The DON stated that she told the GNA not to take care of [resident]. However, she acknowledged that the GNA was allowed to continue with the rest of her assignment on the same unit, and passing by the victim's room. This incident combined with a substantiated abuse occurrence from 2022 caused the OHCQ to determine there was an Immediate Jeopardy related to abuse and the health and safety of the residents on 1/13/25. 31982 Facility reported incident #MD00185366 was reviewed on 1/8/25 at 10:15 AM. The facility report indicated: on 1/11/22 a family member reported Resident #901 alleged that the previous morning s/he called an employee a bitch and the employee smacked him/her on the mouth and told him/her not to call her names. 5 written statements were obtained from staff. GNA10 indicated in her statement that while providing care on the evening of 10/28/22, Resident #901 reported to her that someone slapped him/her on the face twice during the day in the T.V. room, that she meant to report it but forgot. Staff schedules revealed 26 nursing staff worked on Resident #901's unit between 10/28/22 and 10/30/22. No statements were obtained from the other 21 nursing staff as well as any other facility staff including but not limited to dietary, activities, rehab, and housekeeping, who may have interacted with or observed Resident #901 between 10/28/22 and 10/30/22. During an interview on 1/9/25 at 10:31 AM the DON confirmed that the police were not notified of Resident #901's abuse allegation and that GNA#10 failed to immediately report the allegation of abuse on 10/28/22. When asked if she expanded the investigation once she received GNA10's staff statement. She confirmed she was aware of GNA#10's statement. However, she wasn't sure why she didn't get more staff statements. 3. Facility reported incident #MD00182604 was reviewed on 1/9/25 11:30 AM. The report and written witness statement revealed that on 4/25/22 at approximately 11:30 PM, LPN (Licensed Practical Nurse) #3 witnessed a GNA physically abused Resident #905. LPN#3 did not report the incident until 4/26/22 at approximately 6:03 PM. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON confirmed these findings on 1/9/25 at 4:30 PM that LPN#3. The surveyor requested the facility's verification of the required abuse training for LPN#3. The DON indicated - she was an agency staff. We don't have her abuse training. Then stated, the agency provides us with their license, background checks, the things that are required in Maryland, but we don't get their abuse training. Cross reference F 835.

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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. 31982 Based on review of the medical record and interview with staff it was determined the facility staff failed to maintain complete and accurate medical records. This was evident for 1 (#901) of 9 residents reviewed for Abuse. The findings include: Facility reported incident #MD00185366 was reviewed on 1/8/25 at 10:15 AM. The facility reported that on 10/31/22, Resident #901 told his/her daughter that the previous morning he/she called an employee a bitch and the employee smacked him/her on the mouth and told him/her not to call her names. The Director of Nursing (DON) reported the incident to the state agency an began an investigation. In an interview on 1/8/25 at approximately 10:30 AM the Director of Nursing (DON) was asked identified that a resident's change in condition should be documented in a narrative note in the progress note section of the Electronic Medical Record (EMR). Review of Resident #901's medical record at that time revealed 17 Nursing Progress Notes written between 10/27/22 - 11/5/22. 1 note was a routine skin evaluation note dated 11/3/22 10:55 which stated, Skin warm and dry, skin color WNL (within normal limits) and turgor is normal. Neither this nor any of the other notes included documentation reflecting Resident #901's allegation of abuse, an assessment of the resident specific to the allegation of abuse including but not limited to evidence of injury, the resident's mental status, notification of the physician, and measures that were put into place.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 31982 Based on record review and staff interview it was determined the facility failed to ensure that all nursing staff received training on abuse which included procedures for reporting incidents of abuse, neglect, exploitation, and misappropriation of resident property. This was evident for 1 (#905) of 9 residents reviewed for Abuse. The findings include: Facility reported incident #MD00182604 was reviewed on 1/9/25 11:30 AM. The report and written witness statement revealed that on 4/25/22 at approximately 11:30 PM, LPN (Licensed Practical Nurse) #3 witnessed Geriatric Nursing Assistant (GNA) #7 physically abused Resident #905. The facility's initial report to the state agency revealed that LPN#3 did not report the incident until 4/26/22 at approximately 6:03 PM when she informed the Director of Nursing (DON). During an interview on 1/9/25 at 4:30 PM the DON confirmed that LPN#3 failed to immediately report the incident and that GNA#7 continued to provide care for residents from 11PM 4/25/22 - 7 AM 4/26/22, and again on 4/26/22 from approximately 3 PM until 6:03 PM. She indicated that LPN#3 was an agency staff member who worked in the facility. The surveyor requested the facility's verification of the required abuse training for LPN#3. The DON indicated - she was an agency staff. We don't have her abuse training. Then stated, the agency provides us with their license, background checks, the things that are required in Maryland, but we don't get their abuse training. Cross reference F 600 and F 609.