

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke CT Skilled Care Ctr at Bayleigh Chase		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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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. Based on observation and interview, it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service. This was evident during the initial tour of the kitchen during the recertification/complaint survey. The findings include: On 03/23/2026 at 8:14 AM, during the initial tour of the kitchen observation of the entrance of the kitchen, there were no hairnets available at the entrance. When the surveyor asked for a hairnet, Dietary Receiver, Staff #4, had to go to the middle of the kitchen to obtain a hairnet for the surveyor. Continued observation at 8:20 AM in the kitchen: Dietary Staff #2 was observed at the dishwashing station without a hairnet. Dietary Staff #3 was seen walking throughout the kitchen wearing a baseball cap; however, their shoulder-length hair was hanging out of the cap and was not covered by a hairnet. A vendor entered the kitchen with uncovered hair to drop off boxes. Director of Culinary Services, Staff #1, also entered the kitchen without a hairnet, proceeding to the middle of the kitchen to retrieve one. Further observations revealed: On 03/23/2026 at 8:25 AM, during observation, the walk-in freezer contained nine uncovered, undated loaves of bread on top of a box. An additional freezer held an undated canister of fruit. A refrigerator contained two tuna filets and a clear container and a larger container of soy sauce, both expired on 03/21/2026; there was also a clear container of artichokes expired on 03/22/2026. On 03/23/2026 at 8:57 AM, an interview was conducted with the Director of Culinary Services. The director stated that expired food should be removed and disposed of. Additionally, the director noted that employees must wear hairnets prior to entering the kitchen. However, a verification check found no hair nets available at the kitchen's entrance. These concerns were shared with the director at the time of the interview. On 03/24/2026 at approximately 1:15 PM, the concern was shared with the Director of Nursing (DON).		

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, interviews and record reviews, it was determined that the facility failed to ensure that call bells were kept within residents' reach. This was evident for 2 (Residents #8 and #60) of 60 residents observed during the recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and outside agencies. On 3/23/2026 at 8:55 AM, During the initial tour of the facility, Resident #8 was observed in bed. However, the call button was located on top of the recliner approximately 4 feet away from the left side of the bed. At 9:03 AM, the surveyor also observed a call bell pad on the floor under Resident #60's bed. On 3/23/2026 at 9:15 AM, Geriatric Nurse Assistant (GNA #5) was notified of the findings and confirmed that call bells should be placed within residents' reach. On 3/24/2026 at 9:10 AM, a review of Resident #8's medical record revealed a diagnosis of Hemiplegia and Hemiparesis (weakness or paralysis on one vertical side of the body) affecting the right dominant side. A review of the Resident #8's Quarterly MDS with an Assessment Reference Date (ARD) of 2/18/2026, confirmed the following: a. Section GG: Functional abilities/ limitations was coded impairment on one side (upper and lower). b. Section GG: Bed mobility-Roll left and right: (the ability to roll from lying on back to left and right side and return to lying on back on the bed) was coded Dependent (helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.) c. Section GG: Transfer-Chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair) was coded as Dependent. d. Section B: Hearing/Speech- Speech Clarity coded as unclear speech (slurred or mumbled words.) Resident #8's care plan, initiated on 4/10/2023 revealed: Encourage me to my use bell to call for assistance as needed- keep it within my reach at all times. On 3/24/2026 at 9:49 AM, a review of Resident #60's medical record showed a BIMS (Brief Interview for Mental Status) score of 4.0 which indicated impaired cognition. A review of the Resident #60's Quarterly MDS, with an ARD of 3/10/2026 confirmed the following: a. Section GG: Functional abilities/ limitations was coded no impairment on both sides. b. Section GG Bed mobility-Roll left, and right was coded dependent. c. Section GG: Transfer- Chair/bed-to-chair transfer was coded dependent. Resident #60's care plan confirmed these interventions: Anticipate and meet my needs. Date initiated: 9/20/2022 Be sure my call light is within reach. Date initiated: 9/20/2022 Call bell pad to my bed to aid in alerting staff when I need assistance. I have a regular call bell which I do not use all the time. Date Initiated: 1/11/2024 Check on me frequently. Date Initiated: 3/5/2024 I need a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position when in bed. Date Initiated: 9/20/2022 On 3/24/2026 at 11:00 AM, the Director of Nursing (DON) confirmed that Resident #60 utilized a call bell pad due to dexterity issues. The DON was notified of the concerns and acknowledged the findings.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, observation, and review of facility documents it was determined the facility failed to maintain an effective grievance program. This was evident for 1 (Resident #43) of 4 residents reviewed during the recertification/complaint survey. The findings include: According to 42 CFR 483.10(j): A grievance is a formal or informal expression of dissatisfaction regarding care, treatment, services, or the facility's operations. On 03/23/2026, at 9:24 AM, during an interview, Resident #43 expressed concern about the significant loss of clothing, particularly shirts, during the facility's laundry process, despite the items being labeled with the resident's name. Resident #43 reported having notified staff, who assured him/her that they would investigate, but no follow-up information was ever provided. Furthermore, the resident stated that when they spoke to the head of laundry, the response was that the facility could not control the actions of incoming laundry personnel, as new hires allegedly fail to check clothing labels. On 03/24/2026 at approximately 12:30 PM, during observations, it was noted that the facility lacked proper posting of the grievance officer's identity. Furthermore, information on how residents could express a grievance and accessible grievance forms were also absent from all areas of the facility. On 03/24/2026 at 11:56 AM, the surveyor requested the facility's resolved grievances for the last six months from the Assistant Director (ADON), who later returned stating, per the social worker, the facility has not had any grievances since 2022. On 03/24/2026 at 12:22 PM, during a review of the facility form titled Grievance/Complaint Report, there were the instructions for This form shall be utilized to provide written documentation of any concern expressed by a resident or resident representative and to record the follow-up action taken and results thereof. On 03/24/2026 at 12:28 PM, Licensed Practical Nurse (LPN) Staff #16 stated that upon a resident presenting a concern, she would ascertain the nature of the issue and verbally inform the relevant department. On 03/24/2026 at 12:41 PM, during an interview, Social Worker (SW) Staff #8 explained that resident concerns are addressed immediately, and residents/families are informed verbally, requiring no written documentation. She verified that no grievance postings or forms are accessible to residents. When asked about the grievance officer, she stated, I think that it is me, adding she has the binder but needs to check if she is the grievance officer. On 03/24/2026 at approx. 1:35 PM, the Director of Nursing (DON) informed the surveyor that the administrator of the facility is the grievance officer. On 03/24/2026 at 3:35 PM, the administrator/grievance officer explained the grievance process. Grievance information is in the admission packet and covered in resident council. Staff report (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grievances to a supervisor, leading to an investigation usually resolved quickly, or documented on a grievance form if not. He confirmed no posting of the grievance officer or grievance forms were accessible to the residents and that there had been no documented grievances since 2022. The concern was then shared with the administrator. On 3/25/26 at 9:09 AM, the surveyor reviewed a complaint indicating that Resident #43 received inappropriate care from a nursing staff member on 1/21/26. The resident reported the incident to Staff #23 (Activity Staff), stating he/she was disrespected by nurse aide staff during the bed bath and was upset. A subsequent review of Resident #43's medical record revealed no documentation regarding this incident. During an interview on 3/25/26 at 9:27 AM, the Director of Nursing (DON) verified that no self-reported incident or grievance had been filed regarding the resident's experience on 1/21/26. In an interview on 3/24/26 at 3:30 PM, Staff #6 (Assistant Director of Nursing) explained that she received a report of the incident from Staff #15—who had been notified by Staff #23—who on 1/21/26 at approximately 10:30 AM. Staff #6 stated that because Resident #43 denied it was abuse during the facility's internal interview, no formal report, abuse allegation, or grievance was created. Staff #6 further noted that because the facility addressed the issue immediately, they believed it did not require a formal grievance filing. On 3/24/26 at approximately 4:00 PM, the surveyor shared concerns regarding the facility's failure to process Resident #43's experience as a formal grievance. Staff #6 validated these concerns.		

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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. Based on a review of facility records, medical records, and staff interviews, it was determined that facility staff failed to report an allegation of potential abuse immediately. This was evident for two (Resident #18 and #72) of five residents reviewed for allegations of abuse during this recertification/complaint survey. The findings include: 1) A facility-reported incident involving Resident #72 was reviewed on 3/23/26 at 11:56 AM. The report indicated that on 11/05/25, at approximately dinner time, two nursing staff members (Nursing Aide #19 and Registered Nurse #11) overheard Resident #72's spouse saying to the resident, I will shoot you and I will shoot myself. However, the incident report to the State agency on 11/10/25 which was five days later. The facility report included a statement from RN #11 dated 11/10/25, which noted: On November 5th, 2025, I noted [Resident #72 and his/her spouse] in their room conversing. I overheard [the spouse] say, 'I will shoot you and then I will shoot myself.' I immediately went to my superior, the Director of Nursing (DON, Staff #12). I informed her of what I overheard and asked what I needed to do moving forward. I was informed that nothing needed to be done. A written statement from Staff #20 (former Nursing Home Administrator) dated 11/11/25 indicated: RN #11 stated that she told Staff #12 about the incident on Wednesday, November 5, 2025. Staff #12 stated, '[Resident #72's spouse] is a lawyer and he/she talks like that all the time; do not put that in the chart and do not worry about it.' During an interview on 3/23/26 at 3:22 PM, RN #11 verified that she overheard the spouse's threat on 11/05/25 and immediately reported the incident to Staff #12 (former DON). In a subsequent interview on 3/23/26 at 3:39 PM, the current DON stated, I was not here when the incident occurred. I am not 100% sure, but this incident might be related to Staff #12's termination. On 3/24/26 at 12:36 PM, the surveyor confirmed that Staff #12 was terminated on 11/14/25 for failing to report the spouse's threat. During the exit conference on 3/25/26 at approximately 1:30 PM, the surveyor shared concerns regarding the threat made by Resident #72's spouse. The NHA and DON validated that the former DON failed to report the incident in a timely manner. 2) A review on 3/23/26 at 1:44 PM of a facility self-reported incident (#2650043) revealed that on 10/21/25 at 2:00 PM Resident #18 said to the activities director (Staff #21) that staff handled them roughly while getting dressed. The nursing home administrator reviewed the resident council meeting notes on 10/22/25 at 12:15 PM and noted the allegation. An investigation into the allegation started immediately and the Administrator began the notification process. The Director of Nursing was notified at 12:16 PM. Police were called at 12:45 PM. The Medical Director was called at 1:00 PM. The Responsible Party was called at 2:00 PM. The resident was assessed and no injuries were found. The police conducted an investigation and could not determine if abuse occurred. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When a resident alleges abuse or any treatment by an individual such as rough handling that may constitute abuse then it must be reported immediately to the Administrator so that the facility can take steps to protect the resident, so that it could be reported to the state agency, and so that the facility can initiate an investigation immediately. The Director of Nursing was interviewed on 3/23/26 at 2:35 PM. She was asked about the incident and what transpired as a result. She responded that she was not here at that time and neither was the current Administrator. She said she was told of the incident including that the Activities Director was informed of the potential abuse and the fact that the Administrator was only made aware because he reviewed the resident council notes the next day. She said the Activity Director should have reported it immediately. This surveyor then said this will be a concern that the team will take back to the office. She said she understood and then offered that the Activity Director no longer works here.		

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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. Based on a medical record review, a facility investigation review, and staff interviews, it was determined that the facility failed to thoroughly investigate allegations regarding an injury of unknown origin. This was evident for one (Resident #39) of 9 residents reviewed for self-reported incidents during this recertification/complaint survey. The findings include: A review of self-reported incident #2725592 on 3/24/26 at 1:05 PM revealed that on 1/24/26, Registered Nurse (RN) #22 noted Resident #39 was tearful and reported, He hit me. According to the facility's investigation, the resident showed RN #22 a raised hematoma with blue/green bruising located on the left side of the forehead at the hairline. The facility's documentation did not contain an investigation or evaluation of Resident #39's statement, He hit me, nor did it include a psychological assessment. Additionally, there were no interviews or statements from other residents regarding the possible abuse allegation. During an interview with the Director of Nursing (DON) on 3/24/26 at 2:11 PM, she stated that facility staff should interview employees and residents when investigating an injury of unknown origin. She validated that no other residents were interviewed and that no clinical evaluation was performed regarding Resident #39's specific statement.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record reviews, and interviews, it was determined that the facility failed to ensure that the resident's environment remained free of potential accident hazards. This was evident for 1 (Resident #15) of 5 residents reviewed for accident hazards during the recertification/complaint survey process. The findings included: BIMS The Brief Interview for Mental Status (BIMS) is a 0-15 point assessment tool used to measure cognitive function of long-term care residents. Scores categorized as 13-15 (intact), 8-12 (moderate impairment), or 0-7 (severe impairment). The Minimum Data Set (MDS) is a standardized comprehensive assessment tool that measures health status in nursing home residents. On 03/23/2026 at 8:49 AM, during the initial facility tour, the surveyor observed three unattended white pills in a small medication cup on Resident #15's bedside table. On 03/23/2026 at 8:54 AM, in an interview with Registered Nurse (RN) #17, RN #17 was informed of the unattended medication. RN #17 explained that leaving the medication was the only way he could get the resident to take it. When asked, he was unsure if the resident's care plan authorized independent medication administration and noted that the resident was confused at times. RN #17 acknowledged the surveyor's concern regarding the potential hazard of unattended medications. On 03/23/2026 at 12:55 PM, a review of Resident #15's care plan revealed the resident had a diagnosis of dementia, with no documented evidence to suggest the resident was able to self-administer medications. On 03/23/2026 at 1:14 PM, in an interview with RN #9, she explained the facility's criteria for self-medication administration, which required a resident assessment (including being alert and oriented) and an updated care plan. She explained the general medication administration process, which included the nurse ensuring the resident took the medication. RN #9 stated that it would not be appropriate to leave medication at the bedside. On 03/23/2026 at 1:25 PM, a review of Resident #15's Minimum Data Set (MDS) showed the resident's most recent Brief Interview for Mental Status (BIMS) score in February 2026 was 5, indicating severe cognitive impairment. On 3/23/2026 at 1:30 PM, the facility's Medication Policy, titled Medication Administration and Management M-04.1 (revised 10/19), section #3(i) stipulated, Avoid leaving medication or chemicals unattended, and section #5(i) required the nurse to Observe the resident's consumption of the medication(s). On 03/23/2026 at 1:48 PM, the Director of Nursing (DON) confirmed the facility's expectation for self-administration of medication, which included a self-administration assessment, physician order, updated care plan, and locked storage at the bedside. The DON acknowledged that Resident #15 was (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not a candidate for self-administration of medication due to cognitive impairment. Therefore, the facility failed to prevent a potential medication hazard in the environment of a cognitively impaired resident.		

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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. Based on record review and staff interviews, it was determined that the facility failed to provide appropriate pain management. This was evident for 1 (Resident #57) out of 1 residents reviewed for pain during the recertification/complaint survey. The findings include: Non-pharmacological interventions are methods that manage or reduce pain without the use of pain medication. On 03/24/2026, at approximately 8:35 AM, a review of Resident #57's MAR revealed two standing physician orders: oxycodone HCl Oral Tablet 5 MG (1 tablet by mouth every 6 hours as needed for severe pain); Start Date: 02/10/2026) and ACETAMINOPHEN (Tylenol) TAB 325MG (2 tablets by mouth every 6 hours as needed for mild pain or temperature >101; Start Date: 08/12/2019. On 03/24/2026 at 1:32 PM, a review of Resident #57's MARs and progress notes for February and March 2026 revealed a lack of documented non-pharmacological interventions accompanying pain medication administration. Specifically, in February, non-pharmaceutical interventions were not documented with 5 oxycodone and 3 Tylenol administrations. In March, this omission occurred with 2 Tylenol and 2 Oxycodone administrations. On 03/24/2026 at 2:05 PM, during an interview the Director of Nursing (DON) stated that pain management involves first assessing the pain scale, then following the physician's order. Non-pharmacological interventions must be documented on the MAR under supplement documentation within the pain medication order before administering medication. On 3/24/2026 at 4:03 PM, the DON confirmed no non-pharmaceutical interventions were evident and the concern was shared at this time.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record review and interviews, it was determined that the facility failed to have an effective collaborative communication process for residents receiving hospice services. This was evidenced for 1 (Resident #30) of 1 Resident reviewed for hospice services during the recertification/complaint survey. Findings Included: On 03/24/2026 at 8:44 AM, a care plan review confirmed that Resident #30 was receiving hospice services. On 03/24/2026 at 9:58 AM, in an interview with the Director of Nursing (DON), she was asked about the resident's treatment goals and she reported being unsure of the treatment goal for Resident #30 and was also uncertain about where hospice communication was documented (electronic health record or paper). LPN #16 explained on 03/24/2026 at 10:08 AM that the hospice agency typically documented care notes in their own system and provide documentation for upload to the facility's electronic medical record under the documents tab. In a follow-up interview on 03/24/2026 at 10:30 AM, the DON explained that hospice interdisciplinary group meeting minutes were sent to the facility and were to be uploaded into the resident's health record every 2 weeks. The DON acknowledged that the facility did not receive documentation from the hospice agency after each visit. On 03/24/2026 at 11:07 AM, a review of Resident #30's electronic medical records showed evidence of lack of coordination of care between the hospice agency and the facility. The last updated hospice care service document observed in the electronic health record was dated 02/18/2026. The DON was then asked to explain how staff coordinated care if notes were not updated as required. She explained that the hospice team saw the resident at least weekly and verbally communicated with facility's nursing staff during visits but she admitted that the documentation of hospice services was not always available in the resident's medical record after each visit. The surveyor informed the DON that the facility failed to maintain current hospice service documentation within the resident's medical record. The surveyor explained that without updated information regarding hospice needs, the facility could not ensure that all staff members providing care remained informed of the resident's specific requirements and needs. On 03/24/2026 at 11:40 AM, a review of the hospice agency contract (Page #6) revealed that the hospice agency was required to update the Resident's comprehensive assessment, evaluate progress and response to care, no less than every 15 days.		