

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Resorts of Augsburg		STREET ADDRESS, CITY, STATE, ZIP CODE 6811 Campfield Road Baltimore, MD 21207	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to timely implement treatment recommendations for wound management and apply pressure-relieving devices as ordered. This was evident for 3 (Resident #11, #18, and #7) of 3 residents reviewed for wounds during the complaint survey. The findings include: According to the Centers for Disease Control (CDC), pressure ulcers (bed sores, pressure sores, or decubitus ulcers) are wounds from unrelieved pressure on the skin, per the CDC. They are staged by severity: Stage 1 is persistent skin redness; Stage 2 is partial thickness loss (abrasion, blister, shallow crater); Stage 3 is full thickness loss exposing subcutaneous tissue (deep crater); and Stage 4 is full thickness loss exposing muscle or bone. An unstageable ulcer involves full-thickness skin and tissue loss where the extent of damage is obscured by slough or eschar. According to SOM Appendix PP, standard pressure ulcer care requires weekly assessments documenting location, measurement, stage, and characteristics to track healing and treatment effectiveness. Wounds may be colonized (micro-organisms present without signs of infection) or infected (micro-organisms overwhelm tissue defenses, causing symptoms). Signs of infection include increased or changed exudate, decolorization and friability of granulation tissue, undermining, abnormal odor, epithelial bridging at the wound base, or sudden pain. If no progress is evident within 2-4 weeks, the ulcer, complications, and resident's clinical condition must be reassessed to modify or continue interventions. Although clinical complexity can limit treatment responsiveness, clinicians retaining an unchanged regimen despite a lack of healing must document their rationale. 1) On 07/21/2026 at approximately 9:05 AM in review of Intake #3030286 noted a concern of wound management and infection. On 07/21/2026 at 12:09 PM, a review of Resident #11's re-admission assessment from the hospital, completed on 02/25/2026 at 6:05 PM, (Section 11-Skin) noted a sacrum pressure ulcer, but no further assessment indicated its measurement, stage, and characteristics. On 07/22/2026 at 8:40 AM, a review of Resident #11's care plan (initiated 03/13/2025, revised 05/22/2026) showed sacral skin breakdown and risk for complications. The infection-free goal (revised 05/21/2026) targeted 06/08/2026. 03/13/2025 interventions included ordered analgesia/treatments, an anti-pressure mattress, a wound vac, turning/repositioning, diet/supplements, and labs. Subsequent interventions added a PT evaluation (05/20/2026) and infection monitoring (03/31/2026). However, the care plan was not updated as it still reflected a wound vac from March 2025. On 07/21/2026 at 12:23 PM, a review of Resident #11's wound evaluation notes revealed the following: -Wound Consult (02/26/2026): Sacrum pressure injury, Stage 4. Measurements note a 1.8 x 1.8 x 3.0 dimension (area: 3.24). Tissue composition consists of 80% granulation and 20% slough, presenting with moderate, serosanguineous exudate. Further documentation included risk factors and comorbidities of morbid obesity, a history of healed stage 3 or 4 pressure injuries, depression, diabetes, sensory neuropathy, atrial fibrillation, and congestive heart failure. Which stated the factors could exacerbate the (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 0686 Level of Harm - Actual harm Residents Affected - Few	worsening of the pressure injury and included a goal of prevention of the wound decline.-Wound Consult (03/26/2026) indicated signs of infection (foul odor, pain) and ordered a daily dressing change (collagen, calcium alginate, superabsorbent pad). The sacrum wound description noted moderate serosanguineous exudate, 20% slough, 80% granulation, and increased measurements: L 3.2, W 2.0, Depth 3.0 (Area 6.40). Ciprofloxacin 500 mg PO for 7 days was started on 03/26/2026. However, there was no culture to indicate Ciprofloxacin would be sensitive(the specific bacteria causing your infection can be easily killed or stopped by that antibiotic) to the wound infection. Further review of Resident #11's medical record lacked evidence the Primary care physician was notified of the start of the Ciprofloxacin for wound infection. A review of the March and April 2026 medication and treatment administration records revealed that both the ciprofloxacin and the new wound treatment were delayed by 7 days, not starting until 04/02/2026.-Wound consult (04/02/2026): 7 days post-antibiotic delay and treatment change indicated sacral wound infection with significant foul odor, pain, and inflammation. Description: moderate serosanguineous exudate, moderate odor, and macerated/scarred edges. Tissue: 40% slough, 60% granulation. Size: L 2.8 cm, W 2.0 cm, depth 3.0 cm, and area 5.60 cm².-A wound consult (04/09/2026) recommended changing Resident #11's sacrum treatment to daily and as-needed honey on cut-to-fit calcium alginate, covered with bordered gauze. However, the primary nurse practitioner's (NP) progress note from 04/08/2026 indicated continuing Santyl, while the April 2026 TAR showed no treatment change to Santyl on 04/08/2026, the treatment remained in April of honey on cut-to-fit calcium alginate.-Wound consult (04/30/2026) showed increased size and tunneling (3.1 cm at 6 o'clock; L 2.9 cm, W 2.0 cm, depth unable to determine with 4/10 pain). Periwound/Edge: Unstable, macerated, erythematous, calloused. Exudate: Moderate, serous, yellow, serosanguineous. Bed: Full thickness, biofilm, bioburden, 70% slough, 30% granulation.-Wound consult (05/07/2026): 4 weeks after a recommended treatment change, Resident #11's sacrum wound increased to L 3.5 cm, W 3.5 cm, and depth 3.0 (area 12.25, up from 5.80 last week). Exudate is copious, cloudy, and serosanguineous. Tissue composition is 60% slough and 40% granulation. Plan: Apply honey on calcium alginate to the wound bed and bordered gauze daily. However, despite the lack of healing, there was no documented rationale for retaining the current treatment regimen. On 07/21/2026 at 1:00 PM, a review of Resident #11's Attending Nurse Practitioner (NP) progress notes dated 05/07/2026 showed a worsening sacral wound with copious, cloudy drainage on 05/07/2026, alongside an elevated WBC of 12.2. On 07/21/2026 at approximately 1:03 PM, a review of Resident #11's attending nurse practitioner (NP) progress note dated 05/08/2026 showed an increased WBC of 15.4, prompting a 7-day oral doxycycline course for a suspected wound infection and continued Santyl ointment. No wound culture was in the record to confirm antibiotic sensitivity. Additionally, the May 2026 TAR omitted the Santyl treatment, instead specifying daily and as-needed cleansing of a stage 4 sacral pressure ulcer and applying honey on calcium alginate covered by bordered gauze.On 07/21/2026 at approximately 1:10 PM, a review of Resident #11's dietary progress note dated 05/12/2026 revealed a recommendation for vitamin C and zinc for 2 weeks due to increased wound size. However, a review of the May 2026 medication administration record (MAR) showed no implementation of either medication, and there was no documentation indicating the recommendation was communicated to the physician.On 07/21/2026 at approximately 12:35 PM, a review of Resident #11's wound physician note dated 05/21/2026 (6 weeks post-treatment change) documented continued sacrum wound tunneling (3.4 cm at 12 o'clock). The resident reported 4/10 pain, with no odor noted. The wound description remained: Periwound: Erythematous, unstable moisture-associated skin damage. Edge: Erythematous, macerated, undermined pockets; Exudate: Moderate, serous, yellow, serosanguineous; Tissue: 60% slough, 40% (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	granulation. However, despite the lack of healing, there was no documented rationale for retaining the current treatment regimen. On 07/21/2026 at approximately 12:40 PM, a review of Resident #11's nurse practitioner progress note dated 05/26/2026 revealed Resident #11 had nausea and 3 vomiting episodes yesterday; given Zofran x1. Completed a 7-day course of doxycycline 10 days ago for a sacral wound infection. Labs showed worsening leukocytosis with WBC at 31.1, up from 13.6 on 05/22/2026. Resident #11 was sent to the hospital and admitted. On 07/24/2026 at 9:26 AM, during an interview, the facility's current nurse practitioner wound consultant stated that wound infections are identified by drainage, purulent drainage, odor, necrotic tissue, and increased pain. Once identified, she cultures the wound before starting antibiotics to ensure bacterial sensitivity, though broad-spectrum options can be used initially while awaiting results. Delaying antibiotic treatment causes wound deterioration which requires close monitoring, and an ineffective two-month course can lead to sepsis. Regarding comorbidities, she noted that residents with infections can still achieve successful wound healing, though those in late-stage disease progression are less likely to respond. On 07/22/2026 at 11:38 AM, during an interview, the Director of Nursing (DON) stated that a nurse assists twice weekly, conducting wound rounds with the wound physician on Thursdays and completing documentation on Fridays. Wound physician recommendations are documented in progress notes and require approval from the primary care physician. The DON expects any recommended treatment changes or antibiotics from a wound consult to be updated in real time. Additionally, dietician recommendations are expected to be implemented, which the facility reviews daily via progress notes or is discussed at weekly risk meetings. 2a) On 07/23/2026 at 9:22 AM, in review of Resident #18's medical record revealed a physician order dated 06/26/2026 for moon boots while in bed every shift. On 07/23/2026 at 9:20 AM, during an observation Resident #18 was laying flat on his/her back in bed, with moon boots on a windowsill on top of the air conditioner. On 07/23/2026 at 10:03 AM, during an interview with Staff #9 Registered Nurse (RN) explained moon boots are to be on while in bed per the direction of the treatment administration record (TAR). Staff #9 confirmed the boots were not on Resident #18 and applied them in the surveyor's presence. On 07/23/2026 at 2:59 PM, during an interview with the Director of Nursing (DON) stated that if a physician orders moon boots, she would expect the resident to have them on in bed for wound prevention. 2b) On 07/23/2026 at 10:29 AM, during an observation, Resident #7 was lying in bed with an air mattress that appeared non-functional, as its settings indicated no lights were on and Resident #7 appeared sunk in the bed. On 07/23/2026 at 10:36 AM, during an observation/interview, Staff #10, Licensed Practical Nurse (LPN), accompanied the surveyor to Resident #7's room, verifying the air mattress pump was not functioning. Staff #10 noted the air mattress was not plugged into the wall. Staff #10 plugged it in, causing it to inflate, and stated he had been in the room [ROOM NUMBER] minutes prior without noticing it was not functioning. On 07/23/2026 at 11:21 AM, a review of Resident #7's care plan revealed an alteration in skin integrity due to pressure ulcers/wounds on the sacrum, left and right heels, right first toe, left great toe, left lower buttocks, and right buttock excoriation, placing Resident #7 at risk for complications (Initiated: 07/03/2026; Revised: 07/09/2026). The plan included an intervention for an anti-pressure mattress to maintain skin integrity (Initiated: 07/03/2026; Revised: 07/03/2026). However, a further review of the medical record showed no evidence of how the air mattress's functioning would be monitored. On 07/24/2026 at 11:53 AM, during an interview, the Director of Nursing (DON) stated the facility had no documented process for staff to monitor air mattress functionality, though nurses and GNAs are expected to check them during general rounds. On 07/23/2026 at 11:31 AM, a review of Resident #7's wound consults showed that recommendations from 07/09/2026, 07/13/2026, and 07/20/2026 advised changing the right buttock wound treatment (continued on next page)		

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Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0686 Level of Harm - Actual harm Residents Affected - Few	to twice-daily cleansing, silver alginate packing (including undermining), and a bordered foam dressing. However, further review of Resident #7's July 2026 treatment administration record (TAR) showed only a 07/03/2026 order for daily cleansing with Vashe, calcium alginate, and a foam dressing-to the right buttocks wound. There was no evidence that treatment recommendations from 07/09/2026, 07/13/2026, and 07/20/2026 had been addressed or implemented. On 07/22/2026 at 11:38 AM, during an interview, the Director of Nursing (DON) stated that a nurse assists twice weekly, conducting wound rounds with the wound physician on Thursdays and completing documentation on Fridays. Wound physician recommendations are documented in progress notes and require approval from the primary care physician. The DON expects any recommended treatment changes from a wound consult to be updated in real time.		

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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 record reviews and interviews, the facility failed to accommodate resident's preference. This was evident for 2 (Resident #21 and #16) of 3 residents reviewed for preferences during the complaint survey. The findings include: 1) While investigating complaints #3026105 and #3091620, a tour of the facility on 7/22/26 at 11:10 AM resulted in an observation of the call light screen in the hallway of the first floor nursing unit with a call light summons that was timed at 13 minutes 23 seconds. Observation of this hallway call light screen lasted until the call light was answered and turned off at 18 minutes 15 seconds. During an interview on 7/22/26 at 11:30 AM, Geriatric Nursing Assistant (GNA #19) stated that he/she was with another resident getting them out of bed with a hooyer lift (a specialized mechanical patient hoist used by caregivers to move individuals with limited mobility between a bed, wheelchair or bathroom) . He/she explained that was the reason for the delay in answering the call light. GNA#19 stated, All six of my residents require hooyer lift transfers, it takes all morning to get them up and out of bed. During an interview on 7/22/26 at 11:35 AM, Resident #21 stated, I rang my light because I want to get out of bed to my wheelchair. It takes a long time for them [the staff] to answer. I often don't get up until lunchtime. I like to get up earlier than that. 2) Activities of Daily Living (ADLs) is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, toileting, transferring, and mobility. On 07/21/2026 at approximately 8:00 AM, in review of Intake #3036883, there were noted concerns related to being entirely dependent on staff for mobility and having been left in bed by the geriatric nursing assistant (GNA), causing them to miss a favorite activity. There were other times of being left in common areas from lunchtime until 9:00 p.m. or 10:00 p.m. On 07/21/2026 at approximately 8:05 AM, a review of Intake #3030934 noted a concern related to a resident being dependent on staff for mobility/transfers being left up in a wheelchair for up to 10-12 hours. On 07/23/2026 at 8:56 AM, during an interview with Resident #16, who is dependent and requires a Hoyer lift for transfers, expressed a concern of being left up in the chair for extended periods of time. Resident #16 stated that after staff gets him/her up in the morning, they are often not put back to bed until around 4:00 PM after the next shift arrives. On 07/24/2026 at 8:42 AM, a review of Resident #16's care plan, initiated and revised on 06/18/2026, revealed an ADL deficit from generalized weakness requiring assistance with an intervention that (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included a Hoyer lift for transfers. However, further review of Resident #16's medical record lacked evidence of the resident's preference regarding the duration of being out of bed in a chair. On 07/23/2026 at 9:07 AM, during an interview, Staff #7 Geriatric Nursing Assistant (GNA) expressed staffing concerns, noting that when staff don't show up, this delays providing care to residents. They noted that short staffing causes delays for residents requiring a Hoyer lift, which demands two staff members. On 07/23/2026 at 1:13 PM, Staff #11 Geriatric Nursing Assistant (GNA) expressed staffing challenges, noting that care is delayed because they are attending to other residents. On 07/24/2026 at 11:49 AM, during an interview with the Director of Nursing (DON), it was stated that a resident's preference regarding their time out of bed would be documented in their care plan. The DON noted it could specify details such as a preference to get up before breakfast but return to bed before or after lunch. At this time the concern was shared with the DON.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to accurately reflect Resident #8's preferred language. This was evident for one resident (Resident #8) out of three residents reviewed for discharge. The findings include: On 7/23/26 at 1:45 PM while investigating complaint #3093656, the surveyor reviewed Resident #8's medical records. The review revealed that Resident #8 was admitted to the facility on [DATE]th, 2024 and had a past medical history of, but not limited to, systolic heart failure, vascular dementia, diabetes and atrial fibrillation. Further review of Resident #8's medical records revealed that Resident #8 was care planned for difficulty communicating related to lack/limited user/understanding of English. This care plan focus was initiated on 5/20/2024 and interventions documented on the care plan included: . communicate using yes/no questions and responses when able, teach to use communication book/board/electronic device, utilize interpreter for native language as needed, when talking to patient, use gestures and simple sentences. Additionally, in the facility's electronic medical record (EMR), Resident #8's insurance profile that provides demographic information about the resident noted Resident #8's primary language as Korean. On 7/23/26 at 3:10 PM, the surveyor reviewed Resident #8's Minimum Data Set (MDS) assessment. The quarterly assessment completed in May of 2026, in section A (identification information) documented Resident #8 with the preferred language of English (A1110). During an interview on 7/24/26 at 12:30 PM, GNA #16 (Geriatric Nursing Aide) stated, [Resident #8] was in room [number]. No, he/she did not speak English. During an interview on 7/24/26 at 2:20 PM, MDS Coordinator #18 stated, . When doing the MDS assessments regarding language preference, typically we base it off of the Social Work assessment. During an interview on 7/25/26 at 12:25 PM, LPN # 17 (Licensed Practical Nurse) stated, [Resident #8]. he/she did not speak English. not at all. A review of the [hospital] records for the 6/19/2026 hospitalization by the surveyor revealed multiple notes containing the statement, . [AGE] year old Korean- speaking male/female with a diagnosis of dementia. The facility inaccurately documented Resident #8's preferred language in the recent quarterly MDS assessment.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on facility document review, record review, and interview, it was determined the facility failed to develop a comprehensive plan of care for a resident with known contractures. This was evident for 1 (Resident #9) of 3 residents reviewed for care plans during the complaint survey. The findings include: The Minimum Data Set (MDS) is a comprehensive resident assessment that provides facilities with the information necessary to develop, deliver, and modify care plans based on a resident's status. A care plan serves as a guide to address unique needs, allowing facilities to plan, assess, and evaluate the effectiveness of the resident's care. According to the University of Pittsburgh, a bilateral upper muscle contracture is a permanent, severe tightening and shortening of muscles, tendons, or soft tissues from scarring, fibrosis, or stiffness. This condition reduces range of motion, fixes joint or limb positioning, and may cause chronic pain, locking the arm in a bent position and restricting the ability to straighten the shoulders and elbows normally. On 07/21/2026 at approximately 8:15 AM, a review of Intake # 3054032 noted concerns about a fracture caused by not following an individualized care plan. On 7/22/2026 at 2:16 PM, a review of Resident #9's progress note dated 12/30/2025 at 3:35 PM revealed a pop sound was reported from the right arm during a midline insertion by the Advanced PICC Specialists (APS) nurse. Resident #9 reported 7/10 right arm pain, was medicated for pain, and had a STAT x-ray ordered. On 07/22/2026 at 2:55 PM, a review of the facility's investigation notes dated 12/31/2025 at 1:15 PM revealed that an APS nurse arrived for Resident #9's scheduled midline catheter placement (a soft, 8 to 20 cm long plastic tube inserted into a large vein in the upper arm). While using a vein finder, the APS nurse moved the resident's contracted right arm, and a pop was heard. On 7/24/2026 at 4:00 PM, a review of Resident #9's 12/31/2025 radiology report (exam 11:55 AM, reported 12:14 PM) for right elbow and shoulder x-rays revealed an acute right distal humeral fracture (recent fracture at the lower end of the upper arm bone near the elbow). The right shoulder study was limited due to positioning difficulties, but the distal humerus fracture was noted. On 7/22/2026 at 2:15 PM, a review of Resident #9's diagnosis list included bilateral upper arm muscle contractures. On 07/22/2026 at approximately 2:18 PM, a review of Resident #9's Quarterly MDS (12/22/2025) revealed that under Section GG0115 (Functional Limitation in Range of Motion), 2. Impairments on both sides was selected for Section A, Upper extremity (shoulder, elbow, wrist, and hand). On 07/23/2026 at approximately 3:45 PM, a review of Resident #9's plan of care revealed no evidence of a comprehensive plan of care addressing the interventions, precautions, or care instructions for Resident #9's bilateral upper arm muscle contractures. On 07/29/2026 at 11:00 AM, a review of the occupational Discharge summary dated from 05/05/2025 through 07/30/2025 revealed Resident #9 presented with low tolerance during range in motion (ROM) and stretching tasks and demonstrated 70 degrees of right elbow extension. Further review indicated therapy discharged the resident on 07/30/2026 with staff educated to use a rolled blanket as a mechanical block, however the medical record lacked evidence of implementation. On 07/24/2026 at approximately 3:45 PM, an interview with Staff #15, Certified Occupational Therapy Assistant (COTA), indicated that he was familiar with Resident #9, and therapy was unable to perform minimal stretching on the contracted right arm because Resident #9 could not tolerate it well. On 07/22/2026 at approximately 2:20 PM, a review of Resident #9's progress notes revealed a Nurse Practitioner Note dated 12/31/2025 at 11:15 PM, a follow-up regarding an emergency room (ER) transfer for an urgent orthopedic evaluation of a right distal humeral fracture. Facility imaging on 12/31/2025 showed an acute fracture, prompting the ER transfer, where imaging confirmed an oblique (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interviews, it was determined the facility failed to provide ADL care related to urine incontinence timely to a dependent resident. This was evident for 1 (Resident #16) of 3 residents reviewed for Activities of Daily Living during the complaint survey. The findings include: Activities of Daily Living (ADLs) is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, toileting, transferring, and mobility. The Minimum Data Set (MDS) is a required assessment for all residents in Medicare- or Medicaid-certified nursing homes. It evaluates each resident's health and functional status to help staff identify issues and determine resident care decisions. Assessments are conducted at admission, at regular intervals, and at discharge following set guidelines. On 07/21/2026 at approximately 8:00 AM, in review of Intake #3036883, there were noted concerns related to inadequate and delayed incontinence care. On 07/23/2026 at 8:56 AM, during an interview, Resident #16 voiced concerns related to timely incontinence care, waiting up to 4 hours or more to be changed; he/she was changed this morning, but the last time prior was just prior to going to bed the night before. On 07/24/2026 at 8:49 AM, review of the MDS admission dated 06/24/2026 revealed Section GG Self-care for toileting hygiene (maintaining perineal hygiene, adjusting clothes) was marked as 1. Dependent-Helper does ALL of the effort. On 07/24/2026 at 8:42 AM, during a review of Resident #16's care plan, total bowel and bladder incontinence was revealed due to decreased mobility (initiated/revised on 06/18/2026). The care plan specified providing incontinence care on rounds and as needed, thoroughly washing and drying skin, and changing clothes as needed (initiated 06/18/2026). On 07/24/2026 at 8:39 AM, in review of Resident #16's medical record task section for the documented ADL care section for bladder activity, a lapse in care documentation was shown. The last recorded instance of incontinence care was dated 07/22/2026 at 12:35 PM, noting the resident was incontinent of the bladder. This indicated no incontinence care for Resident #16 was provided, exceeding multiple hours of receiving no incontinence care. On 07/23/2026 at 9:07 AM, during an interview, Staff #7 Geriatric Nursing Assistant (GNA) expressed staffing concerns, noting that when staff don't show up, this delays providing care to residents. On 07/23/2026 at 1:13 PM, Staff #11 Geriatric Nursing Assistant (GNA) expressed staffing challenges, noting that care is delayed because they are attending to other residents. On 07/24/2026 at 11:49 AM, during an interview, the Director of Nursing (DON) expressed that residents who are incontinent of bladder should receive incontinence care every two hours and as needed; the care is then documented in the electronic medical record. This concern was shared with the DON during the interview.		

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NAME OF PROVIDER OR SUPPLIER Resorts of Augsburg		STREET ADDRESS, CITY, STATE, ZIP CODE 6811 Campfield Road Baltimore, MD 21207	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, it was determined the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice by not documenting the continued monitoring of a resident with chest pain. This was evident for 1 (Resident #10) of 3 residents reviewed for change in condition during the complaint survey. On 07/21/2026 at approximately 8:00 AM, in review of Intake #3036883, there was a noted concern related to pain management and care services. On 07/23/2026 at 8:33 AM, a review of Resident #10's progress notes from 04/27/2026 at 12:30 PM revealed a physician note: Resident #10 was seen for a post-urology follow-up and left-sided rib cage pain, with new complaints of left-sided pleuritic chest pain (a sharp, stabbing discomfort that worsens when you breathe in, cough, or sneeze) under the left breast. Resident #10 denied shortness of breath, nausea, or vomiting, and both a chest X-ray and EKG completed on 04/26/2026 were normal. Despite this, Resident #10 still continued to complain of chest pain. In relation to the intercostal pain (discomfort in the chest wall or rib area), the physician ordered a daily 5% lidocaine topical patch, and nitroglycerin 0.4 mg SL was available as needed for chest pain, and continue to monitor. However, although Resident #10's medical record showed vital signs, there was no evidence of continued monitoring for the specific chest pain or ongoing cardiovascular assessments between 04/27/2026 and 04/29/2026, when Resident #10 was found unresponsive. On 07/23/2026 at 8:40 AM, a review of Resident #10's April 2026 medication administration record (MAR) revealed a nitroglycerin sublingual order (0.4 mg, 1 tablet every 5 minutes as needed for chest pain for one day, up to 3 doses; call MD if no relief) dated 04/26/2026 at 4:30 PM. The MAR listed it as available only on 4/26 and 4/27. Although the physician documented that the medication was available as needed on 04/27/2026, the MAR indicated it was no longer available after that date. On 07/23/2026 at approximately 8:40 AM, continued review of Resident #10's nursing progress notes dated 04/29/2026 at 6:45 AM revealed Resident #10 was short of breath and non-verbally responsive (moaning only). Vital signs were normal except oxygen saturation, which was 87%, rising to 91% on 2L nasal cannula. Following a physician order to transfer to the hospital, 911 was called. Resident #10 had emesis on the stretcher and departed at 06:39 AM. On 07/24/2026 at 10:59 AM, during an interview, Staff #22, Nurse Practitioner (NP), stated that although she was not Resident #10's practitioner, a statement to continue to monitor implies active follow-up. She explained that for a resident with chest pain, she would expect documented monitoring of vital signs, appearance, and any shortness of breath, along with a formal cardiac assessment. She would have personally followed up within 24 hours, noting that nitroglycerin should have remained available, clear monitoring instructions would be communicated to nurses, and despite the patient being under another provider, she would have assessed the patient the next day. On 07/24/2026 at 2:17 PM, during an interview with the Director of Nursing (DON), she stated that if a physician notes they will continue to monitor, she would expect subsequent progress notes to document monitoring and resident assessments. The concern was shared at this time.		

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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 that included documentation of non-pharmacological interventions. This was evident for 3 (Resident #7, #9, and #10) out of 3 residents reviewed for pain during the complaint survey. The findings include: Non-pharmacological interventions are methods that manage or reduce pain without the use of pain medication. On 07/21/2026 at approximately 8:00 AM, a review of Intake #3036883, there was a noted concern related to pain management. On 07/21/2026 at approximately 8:15 AM, a review of Intake # 3054032 noted concerns related to an occurrence causing a fracture. 1) On 07/23/2026 at 2:11 PM, a review of Resident #7's medication administration record (MAR) for July 2026 revealed that oxycodone 10 MG (ordered 07/03/2026, 1 tablet by mouth every 8 hours as needed for pain) was administered 14 times. A separate order from 07/03/2026 required documenting non-pharmacological interventions before PRN administration using a 1-10 code key (1. Redirection, 2. Distraction, 3. Reposition, 4. Toilet, 5. Give food/beverage, 6. Activity, 7. Deep Breathing, 8. Close Monitoring, 9. Adjust environmental stimuli, 10. Refer to the nurse's note. However, there was no documentation indicating that non-pharmacological interventions were attempted prior to any of the 14 oxycodone administrations. On 07/23/2026 at approximately 2:15 PM, further review of Resident #7's pain care plan showed no evidence of non-pharmacological interventions prior to administering as-needed pain medication. 2) On 07/22/2026 at 3:26 PM, a review of Resident #9's medication administration record (MAR) revealed a physician order dated 11/05/2025 for Oxycodone 5 MG (1 tablet via G-tube every 6 hours as needed for moderate to severe pain, score 7-10). A separate order required that non-pharmacological interventions be attempted and documented prior to administering PRN medications, utilizing specific code numbers: 1. Redirection, 2. Distraction, 3. Reposition, 4. Toilet, 5. Give food/beverage, 6. Activity, 7. Deep Breathing, 8. Close Monitoring, 9. Adjust environmental stimuli, and 10. Refer to the nurse's note. However, further review of the MAR showed that oxycodone was administered 17 times in January 2026 and 2 times in February 2026, with no documentation indicating that any non-pharmacological interventions were attempted prior to any of these 19 administrations. On 07/23/2026 at approximately 3:45 PM, continued review of Resident #9's pain care plan showed no evidence of non-pharmacological interventions prior to administering as-needed pain medication. 3) On 07/24/2026 at 9:13 AM, a review of Resident #10's April 2026 medication administration record (MAR) revealed a physician order for Tramadol HCl Oral Tablet 50 MG (1 tablet by mouth every 12 hours as needed for pain management). While the medication was administered 12 times, the resident's medical record contained no documentation indicating that non-pharmacological interventions were attempted prior to any of these administrations. On 07/24/2026 at approximately 9:15 AM, further review of Resident #10's pain care plan showed no evidence of non-pharmacological interventions prior to administering as-needed pain medication. On 07/23/2026 at 3:15 PM, during an interview, the Director of Nursing (DON) explained that if a resident has as-needed pain medication, non-pharmacological interventions are documented on the medication administration record and included in the pain care plan. The concern was shared with the DON at this time.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review and staff interviews, it was determined that the facility failed to administer medications to treat urinary tract infections as ordered by a physician. This was evident for 2 (Resident #17 and #7) of 4 residents reviewed for infections during the complaint survey. The findings include: According to the Centers for Disease Control and Prevention (CDC), urinary tract infections (UTIs) develop when bacteria from the skin or rectum enter the urethra. On 07/21/2026 at approximately 8:00 AM, in review of Intake #3036883, there was a noted concern related to a urinary tract infection that progressed to sepsis (a life-threatening emergency caused by the body's extreme response to an infection, which most commonly originates in the lung, urinary tract, skin, or gastrointestinal tract). 1) On 07/23/2026 at 12:04 PM, a review of Resident #17's medication administration record (MAR) revealed a 7-day physician order (dated 07/18/2026 at 07:13 AM) for Cefuroxime Axetil Oral Tablet 500 mg twice daily for a UTI, set to stop on 07/24/2026. Both doses on 07/18/2026 were marked NA (awaiting delivery, physician notified), delaying the start until 07/19/2026, and the 10:30 PM dose on 07/21/2026 was omitted. Consequently, Resident #17 would receive only 5 1/2 days of the medication. On 07/23/2026 at approximately 12:06 PM, further review of Resident #17's medical record showed no evidence of communication with the physician regarding these missed doses or the shortened prescribed duration. 2) On 07/23/2026 at 2:11 PM, a review of Resident #7's July medication administration record (MAR) revealed a 07/03/2026 order for Macrobid 100 mg, 1 capsule twice daily for a urinary tract infection (UTI) for 5 days (ending 07/07/2026). Both doses on 07/03/2026 were marked NA (awaiting delivery, physician notified), delaying the start until 07/04/2026 and resulting in only 4 days of the medication being administered. On 07/23/2026 at approximately 2:13 PM, further review of Resident #17's medical record showed no evidence of physician communication regarding the missed doses or shortened duration. On 07/23/2026 at 3:15 PM, during an interview, the Director of Nursing (DON) stated that ordered antibiotics should start the same day or the next day. If the medication is in the emergency supply system, a nurse can pull it; if unavailable, they notify the physician and call the pharmacy, documenting the process in a progress note. The DON noted that physicians should be consulted regarding missed doses to extend duration, and administered medication is documented with a checkmark and initials. The concern was shared with the DON at this time.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, it was determined that the facility failed to ensure a functioning call light system for all residents. This was evident for 1 (Resident #6) out of 21 resident call lights observed during initial observations. The findings include:1. While investigating complaint #3091620, during an interview with Resident #6 on 7/21/26 at 1:45 PM, the surveyor observed that Resident #6's call light would light up on the call light faceplate in the room turning the button red but the call signal did not appear on the hallway call light monitor screen.During this interview, Resident #6 stated, They [staff] tell me that the call light is working but nobody comes. It is dangerous because I get short of breath and at night my door is closed so they cannot hear that bell [pointing to a desk bell on Resident #6's bedside table]. They have had someone up to fix it several times and they tell me it is working. They gave me that desk bell to ring too if no one answers the call light. The other day when I was short of breath, I used my phone to call my daughter and she sent my grandson here.I don't have the nurses' station phone number.During an interview on 7/21/26 at 1:57 PM, Licensed Practical Nurse (LPN #20) stated, All the call lights are working now. The residents ring their [call] light and it sends a message to the [hallway] screen. I also get a message across my computer screen at the nurses' station. Then I can walkie [walkie talkie] the GNAs (Geriatric Nursing Aide) to check on the resident.During an interview on 7/21/26 at 3:21 PM, the Nursing Home Administrator (NHA) stated, We [facility] got the new system about two weeks ago. The new call system has all new faceplates. It has a push button. There are screens at the nurses' station and in the hallways that alert the staff that a call light was activated. Everyone, the GNAs, nurses, dining staff, maintenance, activities, managers, they all get walkies. So everyone is notified when a resident rings their light. No, I am not aware of any of them [call lights] being broken.During a telephone interview on 7/22/26 at 10:23 AM, Family stated, I was at an event and my mom called me to tell me that she was short of breath and no one was answering her call light. I sent my son up to check on my mom right away. I left my event and went to the [facility] to check on her. I knew my son would get there quicker so I sent him.On 7/22/26 at 8:35 AM, NHA confirmed that Resident #6's call light was not sending an alert to the hallway call light screen the previous day. NHA stated that the facility audited all the call lights yesterday evening and they are all communicating with the hallway screen now.On 7/22/26 at 11:25 AM, the surveyor observed that Resident #6's call light was communicating with the hallway call light screens.2. While investigating complaint #3026105, during a staff interview on 7/21/26 at 10:05 AM, LPN #4 stated, the residents have those hand (desk) call bells related to when the [call light] system was down. I am not sure how long it was down for. The facility got a new system recently.During an interview on 7/21/26 at 3:21 PM, the NHA stated, Since the new [brand name] call light system has gone in the past 2 weeks, we have not had any grievances about call lights.Previously, we were supplementing the existing call light system with bells on the bedside table and frequent rounding.We had one issue with the old system- you rang the call light and it went to a pager. Each GNS had a pager. The pagers started going wonky about April. We were doing more frequent rounds and gave the residents bedside bells. We did not report it to the State agency because we felt we were handling it.		