STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215220	A. Building B. Wing	01/16/2025

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Chapel Hill Nursing Center	4511 Robosson Road Randallstown, MD 21133

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 51213 Based on review of a facility reported incident, record review and staff interview, it was determined that the facility administration failed to ensure that a background check was done to protect residents from abuse, neglect, and theft. This was evident for 4 (Staff #26, # 46,# 47, and #48) of 9 employees reviewed for abuse during the re-certification survey. The findings include: 1) On 1/10/2025 at 2:05 PM the Director of Human Resources, Staff #25, was interviewed and asked if GNA #26 had a background check in their employee file. On 1/10/2024 at 2:40 PM Staff #25 was not able to provide a background check for GNA #26 after they reviewed the paper employee records and the electronic employee records. On 1/13/2025 at 8:00 AM Staff #25, the Director of Human Resources was asked again if GNA #26 had a background check in their employee file. Staff #25 replied no, I do not have any paperwork or documentation that showed GNA #26 had a background check during her employment here. 2) On 1/13/2024 at 8:15 AM the Administrator provided their facility reported incident (FRI) for MD00174862. In-services/ training for the staff for this incident were requested from the Administrator as well as the employee's files for the staff whose initials were listed in the FRI for alleged verbal abuse. On 1/14/2024 at 3:00 PM the Administrator was asked for the full names of the following employees: GNA #46, LPN #47 and GNA #48 whose initials were listed on the FRI. The Administrator stated he was not sure who these employees were based on just their initials and therefore could not provide their employee files to show that background checks were completed on GNA#46, LPN#47, and GNA #48.

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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	215220	A. Building B. Wing	01/16/2025

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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. 51128 Based on review of facility records, Medical records, and interview with staff it was determined that the facility staff failed to immediately report an allegation of suspected resident abuse. This was evident for 1 (#37) of 15 residents reviewed for self-reported incidents during this recertification survey. The findings include: A facility self-reported incident involving Resident #37 was reviewed on 1/9/2025 at 11:01 AM. It was indicated that an allegation of abuse was reported on 12/19/2024 by the ombudsman during a care plan meeting. The family of Resident #37 reported to the ombudsman that a GNA (Geriatric Nursing Assistant), GNA #29, threw a positioning wedge pillow at him. Further review of the facility's investigation packet revealed that it had the following timelines documented: -The alleged incident occurred on 12/15/2024 at 8:45 PM -Nursing Home Administrator (NHA) was notified of the incident on 12/16/2024 -NHA interviewed Resident #37 on 12/17/2024 -NHA interviewed GNA #29 on 12/17/2024 -Ombudsman reported the incident at the Care Plan Meeting on 12/19/2024 -The incident was reported to the Office of Healthcare Quality (OHCQ) on 12/19/2024 at 1:50 PM Further review of the incident packet had copies of a typed statement for Resident #37 signed by the NHA on 12/17/2024 which stated that GNA #29 was putting a wedge under his feet but was having a hard time understanding the instructions. GNA #29 got discouraged and placed the wedge on the bed by his feet and said she/he would come back later. Resident #37 stated that GNA #29 did not throw the wedge at him/her or intended to hurt him/her, but he/she could see that he/she did not understand the instructions. A typed statement was for the roommate, Resident #38 signed by the NHA on 12/17/2024 stated that GNA #29 was discouraged when she could not understand Resident #37 and put the wedge down on the end of the bed and said she would come back later because she needed a breather. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/2025 at 2:05 PM, an interview was conducted with the NHA. When asked about reporting time for abuse, he stated that it is within 2 hours of hearing about an alleged abuse. NHA stated that Resident #37 was interviewed on 12/16/2024 and denied the incident happened, so therefore he did not report the incident to OHCQ at that time. When the NHA was asked if the interview was part of an investigation, the NHA said that since it was denied by Resident #37 and Resident #38, it was not reported. However, on 12/19/2024 at Resident #37's care plan meeting, when the ombudsman stated that the abuse was reported to her office, the facility then reported it to OHCQ. On 1/16/2025 around 9 AM, the surveyor shared that this was a concern with the Director of Nursing and the NHA.

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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. 43096 Based on medical record review, facility investigation review, and staff interview, it was determined that the facility failed to 1) thoroughly investigate a resident's allegation of unknown origin of injury, 2) educate all staff to prevent similar elopement episodes in the future, and 3) thoroughly investigate an allegation of abuse, and provide documentation for the incident of an allegation of abuse. This was evident for 3 (Resident #30, #23, #19) of 36 residents reviewed during this recertification/complaint survey. The findings include: 1) A review of the facility's self-reported incident, MD00187097, on 1/09/25 around 10 AM revealed that Resident #30 was found with a bruise on his/her left flank and coccyx on 12/28/22. The facility investigated this incident as an unknown origin of injury through staff interviews, hospital follow-ups, and ADL (Activities of Daily Living) evaluations. However, there was no documentation for other residents' interviews. On 1/09/25 at 1:05 PM, the surveyor interviewed the Nursing Home Administrator (NHA). The NHA stated that the facility staff performed residents' interviews (if they were capable) to verify their safety when an unknown origin of injury was reported. The surveyor reviewed the investigation of Resident #30's reported incident with the NHA. He validated that there were no other resident interviews. 2) On 1/13/25 at 10:14 AM, the surveyor reviewed the facility's investigation documentation for self-reported incident, MD00174880. The incident stated that Resident #23 left the facility building on 11/27/21, which was noticed by a staff member (#36). The staff member followed the resident and brought him/her back to the facility. Further review of the facility's investigation revealed that the facility failed to interview Staff #36, who initially saw Resident #23 leave the building via camera. Also, it was noted that the facility provided in-service training to staff about 'Supervision during smoke break' and 'Resident safety' on the same day the incident occurred. However, the training attendance record indicated that only 9 nursing staff members, including Nurses and aides, signed. During an interview with the Nursing Home Administrator (NHA) on 1/13/25 at 12:47 PM, he confirmed that the facility had more than 9 nursing staff members. He stated that he expected to educate all staff about the elopement incident to prevent a similar event. Also, the NHA verified that the facility's investigation did not include a statement/interview with Staff #36. The surveyor shared concerns, and the NHA validated them. 51213 3) On 1/10/2025 at 9:02 AM records reviewed of facility investigative material, revealed the Initial report for MD00163206 was filed with The Office of Healthcare Quality (OHCQ) on 2/3/2021 at 7:15 AM involving an allegation of abuse from employee to resident. The final report was also filed with OHCQ on the same day 2/3/2021 and at the same time 7:15 AM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/2024 at 12:40 PM the Administrator was interviewed and asked if they had a copy of the final report within 5 days of the incident with the conclusion of the investigation? The Administrator replied, when I spoke with the former Administrator, I was told the report was filed and completed on the same day. The Administrator was then asked if they could provide any witness statements from the employees that worked with Resident #19, the alleged abused person, about what happened during the time the abuse was reported. And if any skin assessments were completed on the other residents the GNA # 26 took care of during that shift? And any documentation about abuse training that was given to all staff after the incident. The Administrator replied, No I have given you all the documentation that I have pertaining to this incident.

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	215220	A. Building B. Wing	01/16/2025

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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** 43096 Based on medical record review and staff interviews, it was determined that the facility staff failed to ensure that Minimum Data Set (MDS) assessments were accurately coded. This was evident for one (Resident #257) of three residents reviewed for smoking during the recertification/complaint survey. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Residents' strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. A portion of the investigation into a facility-reported incident, MD00185418, on 1/13/25 at 10:00 AM revealed that Resident #257 was found smoking in the room on 11/09/2022. The facility staff confiscated the Resident's smoking materials, and an evaluation and audit were conducted. The surveyor reviewed Resident #257's medical records on 1/13/25 around 1 PM. The review revealed that the resident was admitted in October 2022, and the initial smoking assessment was completed upon admission. However, the resident's MDS assessment dated [DATE] documented no cigarette in use. During an interview with Staff #34 (MDS coordinator) on 1/13/24 at 1:25 PM, Staff #34 said that smoking status should be assessed each time- initial, quarterly, and any significant change occurred. On 1/14/25 at 11:32 AM, the Nursing Home Administrator (NHA) was interviewed. The NHA was informed of the above inaccurate MDS record in Resident #257's initial MDS, which he validated.

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	215220	A. Building B. Wing	01/16/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43096 Based on the medical record review and staff interview, it was determined the facility staff failed to revise the interdisciplinary care plans to meet the resident's needs. This was evident for 2 (Resident #30, #13) of 9 residents reviewed for abuse and 36 residents reviewed for for care plan timing and revision during the survey process. 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. The interdisciplinary team meets and develops care plans once the facility staff completes a comprehensive resident assessment. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the resident's specific needs. The care plan is a means of communicating and organizing the actions and assuring the resident's needs are attended to. The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan are accurate and appropriate for the resident. 1) During a portion of investigating the facility's self-reported incident, MD00212723, on 1/09/25 at 9:51 AM, it was noted that Resident #30 had reported on 12/14/23 that he/she did not feel safe returning due to he/she was touched by someone. Further review of the facility's investigation packet revealed that the facility started investigating this incident on 12/14/24, including interviewing staff and other residents. The interview revealed no visitors for Resident #30 before the incident. Also, their investigation revealed that Resident #30 had a same-gender roommate. During an interview with the Nursing Home Administrator (NHA) on 1/09/25 at 11:00 AM, he stated that the facility concluded that no opposite-gender visitors or staff cared for Resident #30 before the incident. He noted that the resident was confused that he/she had an opposite-gender roommate, and they touched Resident #30. On 1/09/25 around 2 PM, the surveyor reviewed Resident #30's care plan. The review revealed that there was no updated care plan after the incident. In an interview with the Director of Nursing (DON) on 1/09/25 at 2:30 PM, she stated that the DON or the Assistant Director of Nursing should update/revise residents' care plans upon their admission, regularly, and as needed. On 1/10/25 at 8 AM, the surveyor reviewed Resident #30's care plan with the DON. The DON verified that the care plan was not updated after the incident. 49409 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 01/10/25 at 11 AM, a medical record review for Resident #13 revealed that an initial order from 12/15/23 for Ativan Tablet 0.5 MG every 12 hours as needed for anxiety was placed for 14 days. The order was renewed to manage resident behaviors on 01/02/24 for 14 days, 01/22/24 for 14 days, and 02/19/24 for 14 days. The interdisciplinary team care plan goals and interventions did not reflect Resident #13's behavior changes requiring anxiolytic administration (Ativan). The Activity's care plan goals were initiated during the resident's admission on 12/18/2023, and a revision was done on 01/08/2025. Interventions were also initiated on 12/18/2023 without any specific interventional updates. A review of individual residents' daily participation records reflects resident participation, but does not reflect the effectiveness or outcome of the activity offered. Review of quarterly activity assessments dated 03/11/24, 06/04/24, 08/29/24, 11/22/24 a) doesn't reflect revised goals or interventions, b) changes to activity focuses (Revised strengths, problems, preferences); not answered, c) describe changes to goals, not answered, d) describe changes to interventions /approaches; not answered. An interview with staff # 51 on 01/13/25 at 09:14 AM confirmed that the Activity Director updates the care plans to reflect any change in resident care. This was reviewed and confirmed with the Activity Director, Director of Nursing (DON), and the Nursing home administrator (NHA) that the facility staff failed to review and revise care plans for Resident # 13 to reflect current and appropriate interventions.

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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. 51128 Based on medical record review and resident and staff interviews it was determined the facility staff failed to ensure that the dependent resident's personal hygiene needs were adequately met by offering and providing showers as scheduled. This was evident for 1 (Resident #37) of 2 residents reviewed for Activities of Daily Living (ADL) during this recertification/complaint survey. The findings include: During an interview with Resident #37 on 01/09/25 at 11:43 AM, when the surveyor asked the Resident if he got showers, the Resident stated Heck no. when asked if he would like a shower, he said Yes. On 1/13/2025 at 11:50 AM, an interview was conducted with a Geriatric Nurse Aide (GNA #35) who stated that when residents refused a shower, the GNAs would let the nurse know and document the refusal in the Electronic Health Record. GNA #35 stated that Resident #37 refused showers in the past, and had been getting bed baths. A record Review was conducted on 1/13/2025 at 1:16 PM revealed: -Order for shower and Skin Check 7-3 Shift Tuesday and Friday, written on 12/20/2024 at 07:00 AM. -Resident #37's Brief Interview for Mental Status (BIMS) dated 10/29/2024 revealed a score of 15 indicating adequate cognitive ability. -A care plan with an initiation date of 9/20/2024 and revision on 12/13/2024 indicated that Resident #37 has an Activities of Daily Living (ADL) selfcare deficit related to the disease process with an intervention to provide a sponge bath when a full bath or shower cannot be tolerated. -GNA Task tab within the past 30 days starting on the week of 12/15/2024, the shower dates for Tuesdays and Fridays are 12/20/2024, 12/2/2024, 12/27/2024, and 12/31/2024 had check marks indicating Resident #37 was given a bed bath. There was no documentation that Resident #37 refused a Shower and no documentation that Resident #37 was encouraged to take a shower during this record review. On 1/13/2025 at 12:30 PM in an Interview with the Director of Nursing (DON)and the Nursing Home Administrator (NHA), DON stated that if residents refused a shower, it was documented in the Electronic Health Record. The residents could then be offered a bed bath but were encouraged to take showers. When the DON was informed that Resident #37 stated that he had not had a shower, the DON stated that Resident #37 got a bed bath because the facility shower room did not have a chair that reclined and could not accommodate Resident #37 because of his/her diagnosis. Following that statement, the NHA stated that if Resident #37 wanted a shower he would get one. When asked about shower accommodations for other residents who were disabled and could not sit in a shower chair, the DON and NHA did not provide a response. (continued on next page)

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	215220	A. Building B. Wing	01/16/2025

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Chapel Hill Nursing Center	4511 Robosson Road Randallstown, MD 21133

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/2025 at 08:00 AM surveyor asked Resident #37 if he had a shower on 1/13/2025, Resident #37 confirmed that he was finally given a shower.

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	215220	A. Building B. Wing	01/16/2025

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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. 50904 Based on record review and interview with facility staff, it was determined that facility staff failed to communicate and document a concern about a resident with a contracted dentist prior to tooth extraction which resulted in a resident having gum bleeding after the tooth extraction. This was evident for 1(Resident #264) out of 4 complaint investigations reviewed during the Medicare/Medicaid recertification survey. The findings include: On 01/13/2025 at 9:09 AM, review of intake MD00200513 showed that a complainant had stated that on July 29, 2024 their loved one, who was a resident at the facility, had a dental procedure (tooth pull) and his/ her blood-thinner medication was not held prior to the procedure which caused a trip to the emergency department due to excessive bleeding. On the same day at 9:14, the surveyor reviewed the electronic health record of the resident and it revealed the following: 1. Health Status Note on 7/27/2024 at 13:17 Note Text: Alert and verbal, no distress noted. was seen by a Dentist today. SBAR progress note on 7/27/2024 at 21:38 Note Text: The change in condition, signs or symptoms observed are other changes in condition, substantial bleeding noted from extracted tooth started on 07/27/2024. Primary Care Clinician notified: 07/27/2024 9:13 PM. 2. A progress note on 7/28/2024 at 08:43 AM showed-Note Text: resident returned from ER at 5:46 AM, bleeding profusely from mouth d/t tooth extraction on 7/27/24, via ambulance with daughter. Gauze applied to tooth cavity to stop bleeding, and the writer called on-call to report residents' current status and approval of new recommendation to hold Eliquis until 7/29/24, awaiting response, and an oncoming nurse made aware. 3. Health status note on 7/28/2024 at 10:25PM Note Text: During rounds, resident is actively bleeding from the extracted tooth site. The bleeding has become more substantial. On-call has been notified and recommendation for the resident to be sent out. Vital signs were stable 136/62, 60, 18, 98% RA and temp 97. 9. Resident left dry and clean. The patient has been transported to [Hospital name]. 4. Health status note on 7/30/2024 at 10:55 AM, Note Text: Call place in [Hospital name] ER and ER nurse stated that patient is being admitted . 5. Admission summary on 8/3/2024 01:12 AM, Note Text: Resident is alert and responsive, verbal at times, in no acute distress, Status Post return from hospital, presented to ER S/p tooth extraction with persistent bleeding. Discharge Dx: Oral bleed, bleeding gums. On call nurse practitioner notified of return, orders approved and verified, to resume prior meds / treatments. To start insulin Aspart low dose sliding scale Subq Q6H, Oxycodone 5mg Q24, To resume Tube feeding with Glucerna. The resident remains stable, cont. POC. (continued on next page)

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	215220	A. Building B. Wing	01/16/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/2025 at 12:50 PM, the surveyor reviewed the electronic medication administration record (EMAR) for the resident during that period and it revealed that the resident has been receiving his/her scheduled Eliquis and Aspirin tablets as prescribed and still had them in the morning on the day of the tooth extraction. On 01/15/2025 at 1:15 PM, in an interview with Registered Nurse (RN #19) who administered medications to Resident #264 on 07/27/2024, the day of the tooth extraction. When she was asked what the procedure was for a resident scheduled for tooth extraction, she stated that, the normal thing would have been for the dentist to inform the facility of the visit and if the resident was on any blood thinner, physician would be informed and an order for the blood thinner to be held before the tooth extraction would be obtained. She added that nurses would ensure that the dentist pre-operative orders were kept. She also stated that after the extraction, the nurses followed the post operative orders. When she was informed that she had signed off giving aspirin and Eliquis on the day the resident had the tooth extraction, she stated that she did not know that the dentist was visiting the resident that day as the dentist did not inform the facility of her visits. She also stated that she had informed the dentist that she had administered Eliquis and Aspirin tablets to the resident. When she was asked for the documentation showing that she informed the dentist about the resident receiving the medications prior, she stated that she only informed the dentist verbally. She added that after the extraction was done, she continued to monitor the resident but that later that evening when the bleeding did not stop, she reached out to the dentist, but she was not reachable then she placed a call to the on-call physician who gave an order for the resident to be sent to the ER. On 01/15/2025 at 1:26 PM, the Nursing Home Administrator (NHA) was informed about the complaint, and he stated that the facility stopped using the vendor because of communication problem, when he was asked what he meant by communication problem, he stated that the dentist just visits randomly and did not tell the facility of upcoming visits. When he was asked about consent, he stated that they get consent verbally from residents if they are capable or from family members (Responsible Party) if they are incapable of making decisions. The dentist could not be reached as she no longer works with the facility.

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	215220	A. Building B. Wing	01/16/2025

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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. 50904 Based on the investigation of the facility reported incident, review of medical records and interview with facility staff, it was determined that the facility failed to follow the specified number of staff support needed when providing care for residents. This resulted in the resident falling out of the bed and suffering a left acute frontal subdural hematoma, which required surgery. This was evident for 1 (Resident #264) out of 9 residents reviewed for accidents during the Medicare/Medicaid recertification survey. The findings include: The Brief Interview for Mental Status (BIMS) score is a number between 0 and 15 that indicates a person's cognitive health: 13-15 points: The person's cognition is intact; 8-12 points: The person has moderate cognitive impairment; 0-7 points: The person has severe cognitive impairment. The Minimum Data Set (MDS) is administered to all residents upon admission, quarterly, yearly, and whenever a significant change in an individual's condition occurs. It is a standardized assessment tool to comprehensively evaluate a resident's health status, functional abilities, and needs. It is the foundation for creating a personalized care plan that drives care rendered by the healthcare team within a nursing facility. On 1/09/24 at 09:00 AM, a review of the facility self-reported incident, MD00210423, revealed that Resident #264 had a fall when Geriatric Nursing Assistant (GNA #10) provided morning care on 9/28/24 around 5AM. The report indicated that the fall incident resulted in Resident #264 having an intracranial hemorrhage (also known as brain bleed, is bleeding within the skull or in the brain tissue. It's a life-threatening condition that requires immediate medical attention). Further review of the facility's investigation revealed that: - The facility obtained GNA #10's statement on 09/28/2024. The statement stated that on 9/28/24 around 5 AM GNA #10 admitted to leaving the bed high at her own waist level when she went to perform Activity of Daily Living care(ADL) on Resident #264 and ran out to the bathroom to wet and warm the towel. When she was in the bathroom, GNA #10 heard thud, she came back out and saw Resident #264 was on the floor and she called the nurse. GNA #10 also stated that before she went to the bathroom, the resident was squirming in bed but was able to calm him/her down. - Registered Nurse (RN #11) who was called by GNA #10 for the incident assessed the resident and wrote a progress note on 09/28/2024 at 05:30 AM which stated that assigned GNA reported to nurse that while she was in the room getting ready to provide care to Resident #264 when she heard a loud noise and observed Resident #264 on the floor. On assessment, the resident was noted face down on the floor mat beside his/her bed with a large bleeding. Hematoma noted on the left forehead and the nurse got an order to transfer the resident to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215220	A. Building B. Wing	01/16/2025

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Chapel Hill Nursing Center	4511 Robosson Road Randallstown, MD 21133

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/28/2024 at 11:36 AM, a note signed by License Practical Nurse (LPN #7) showed that [hospital 1] was contacted for an update on Resident #264's status. The resident was transferred from [hospital 1] to [hospital 2] emergency room and admitted to [hospital 2] Surgical Center at 11 am. No other updates at this time. Per statement by the DON on 09/30/2024, GNA #10's appointment was terminated, and she was reported to the board of nursing. On the initial self-incident report dated 10/01/24 at 1:30 PM, it was documented that [hospital 2] informed the facility that Resident #264 had an Intracranial Hemorrhage. On 1/09/25 at 10:20 AM, the surveyor reviewed Resident #264's medical record. The review revealed that the resident was admitted to the facility in August 2024 with a past medical history that included but was not limited to unspecified dementia with behavioral disturbance, other epilepsy, and seizure disorder. The residents' brief interview for mental status (BIMS) score was 10 out of 15 on 08/07/2024. The Minimum Data Set (MDS) assessment on 08/04/2024 revealed that the resident was dependent on activities of daily living (ADL). Also, a care plan initiated on 08/03/2024 indicated that the resident must have 2 persons assist at all times. On 01/10/2025 at 9:47 AM, an interview was conducted with GNA #16, to inquire how ADL care was performed for residents and how she knew the number of required staff for the residents. She stated that usually when they had a new admission, the resident was first assessed by the rehabilitation team before the GNAs provided any care. She added that the rehabilitation team told them the type of assistance the resident would need, and they took over from there. When she was also asked how she set the beds for the residents during ADL care, she stated that she raised the bed to her waist level. When she was asked how she ensured resident's safety while doing ADL care, she stated that she turned the patients towards her if it was a one person assist or towards another GNA if it was a two-person assistance to prevent rolling onto the floor. On 01/10/25 at 09:58 AM, in an Interview with GNA #17, when she was asked how ADL care was provided for residents, she stated that she washed the residents, cleaned their mouths and got them dressed up. When she was asked how she knew the number of required staff for the residents, she stated that it was attached to the wall on the top of the resident's bed. When she was also asked how she set the beds for the residents' ADL care, she stated that she raised the beds to a comfortable level for her. When she was asked how she ensured residents safety while doing ADL care, she stated that she turned the patients towards her if it was a one-person assist and called another GNA if it was a two-person assistance. She also added that she kept the bed low if she needed to step away from the resident. On 01/10/2025 at 11:05 AM during a tour to B wing of Unit 1 with RN #19, When she was asked how staff would know the type of assistance the resident needed, she stated that it was in the resident's electronic record and that she gave them orientation and reminded them at the beginning of the shifts of the type of assistance the residents needed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/10/2025 at 11:14 AM In an interview with Certified Occupational Therapist Assistant (COTA), staff #18, when she was asked how staff members know the type of assistance a resident needed, she stated that upon admission, the Physical Therapist/Occupational Therapist assessed the residents and communicated the assistance with the PTA/COTA. Then the PT/OT developed a care plan stating the type of assistance and communicated it with the nursing staff. On 01/10/25 at 11:30 AM, in an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA), when they were asked how many people were in-serviced after the incident, the DON stated that all licensed nurses and GNA's were in serviced, she added that those who were not around in person were giving the education via the phone. She added that the new hires were educated to know that the Physical Therapist/Occupational Therapist needed to see the residents before they took care of the residents. The administrator was asked to provide a copy of the list of nursing employees during that incident. Additionally, on 1/10/25 around 3 PM, a review of the facility's investigation packet revealed that nursing staff, including 19 GNAs and 17 licensed nurses, received education on 10/01/2024 about resident safety and transfer mobility. However, reviewing the entire nursing staff list revealed that 4 staff (GNA #21, #23, #24, , and Assistant Director of Nursing #1) were not listed on their in-service training records. On 1/13/25 at 7:59 AM, in an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA), when the DON was asked how staff members identify the assistance each resident needed, she stated that the assistance level was indicated in the task in the electronic health record, and that GNAs received reports from the nurses concerning the type of assistance needed by each resident. The NHA added that they stopped posting signs due to HIPPA. The NHA also stated that GNAs could verify care via GNA task in the electronic health record & during shift handover. The surveyors requested a document to support that all GNAs had the same procedure of taking reports from the licensed nurses regarding the required resident assistance levels, but none was provided. On 1/13/25 at 7:50 AM, the Nursing Home Administrator(NHA) and the Director of Nursing (DON) were also informed that the in-service education done did not match the list of nurses employed during that time which included the Assistant Director of Nursing as well. The survey team informed DON and NHA that since the training was not completed and the nursing staff were not aware of the same procedure of taking report from the licensed nurses regarding the required resident assistance levels, this was considered as active harm. On the same day at 08:20 AM, the facility was also asked for a copy of documentation of what the facility did to prevent a similar incident in the future. On 01/14/2025 at 08:30 AM, the NHA submitted copies of interviews with the residents on 10/18/2024 regarding their transfers (the questions included, how do the staff transfer you? Is this the usual way that they transfer you? Do you feel safe?). However, it did not address care received by the residents with accurate numbers of assistance. On the same day at 11:53 AM, the surveyor informed NHA about the findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51128 Based on a review of the medical record and interview with staff it was determined that the facility failed to monitor a resident's significant weight changes. This was evident for 1 (#37) of 2 residents reviewed for nutrition during the recertification/complaint survey. The findings include: On 1/08/2025 at 1:44 PM, a review of Resident #37's medical record revealed, in a weight tracking system report, Resident #37's weight was documented as 187.2 Lbs. (pounds) on 04/08/2024 and 6/18/2024 Resident #37's weight was documented as 166.5 lbs., which was a 20 lbs weight loss. Further review of Resident #37's medical record revealed a note from the dietician, staff #50 on 5/16/2024 that the resident refused weight, noted with failure to thrive in adult, swallowing difficulty, speech more remote/ slurred, and needs 100% support with meals. However, there was no documentation from a physician that he/she was aware of Resident #37's weight loss, nutritional status, or weight management. The weight log was as follows: 8/2/2024 163.2 Lbs 7/24/2024 163.0 Lbs 7/17/2024 163.6 Lbs 7/9/2024 165.0 Lbs 6/18/2024 166.5 Lbs 4/8/2024 187.2 Lbs On 1/13/2025 at 12:00 PM, an interview was conducted with the Dietician, Staff #49. When the surveyor asked how the resident's residual weight is communicated between staff, dietician, and physician, Staff #49 stated that the resident has a right to refuse, but he is encouraged to have the weight done, the refusal is documented, and staff should continue to encourage daily. If it has been over a couple of months, then the physician is notified for further intervention. During an interview with the Assistant Director of Nursing (ADON) on 1/14/2025 at 12:46 PM, when asked what the facility does when a resident refuses weight. The ADON stated that the Geriatric Nursing Assistant (GNA) would let the nurse know that the resident refused weight, document in the Electronic Health Record (EHR), and the nurse would also notify the physician. The ADON also stated that the dietitian would attend morning meetings on Tuesdays or Thursdays and discuss weight loss. On 1/14/2025 at 2:13 PM, a further record review noted that Resident #37 was hospitalized on [DATE]. The resident was readmitted on [DATE]. The weight on 6/18/2024 was 166.5. There was no further weight documented until 7/17/2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/2025 at 3:46 PM, a follow-up phone interview was conducted with staff #49 concerning weight management after re-admission. When asked how the baseline body weight was obtained, Staff #49 stated that a resident's body weight was obtained on admission, within the next 3 days, once a week for 4 weeks, then monthly. The surveyor informed Resident #37's case: the resident did not have these weights documented and there was no documentation of refusal or communication with the provider. Staff # 49 shared her professional opinion that Resident #37 should have been encouraged to get weight and other interventions could have been done such as supplements, providing double portions of food, and notifying the provider. On 1/16/2025 around 9 AM, the surveyor shared the above concern with the Nursing Home Administrator, he validated the concern.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409 Based on the medical record review and staff interview the facility failed to ensure that the use of high-risk psychotropic medication was necessary and justified when staff failed to complete behavior monitoring documentation and utilization of nonpharmacological interventions before administering Anxiolytic medication for the resident (#13). This concern was evident for 1 (Resident #13) of 2 residents reviewed for utilization of unnecessary medication during the recertification survey. The findings include: Resident #13's medical record was reviewed on 01/10/25 at 11:06 AM and revealed that the resident was admitted on [DATE]. Resident #13 was receiving an anxiolytic medication (Ativan) for the diagnosis of Anxiety. On 01/10/25 at 11 AM, a medical record review revealed that an initial order from 12/15/23 for Ativan Tablet 0.5 MG every 12 hours as needed for anxiety was placed for 14 days. The order was renewed to manage resident behaviors on 01/02/24 for 14 days, 01/22/24 for 14 days, and 02/19/24 for 14 days. Further review of resident # 13's medication administration record on 01/10/25 at 11:35 AM revealed that he/she received Ativan 0.5 mg five times in January 2024, on 22nd, 23rd, 24th ,26th, and 29th. Further medical record review on 01/10/25 at 11:45 AM revealed that Nonpharmacological interventions to prevent the usage of psychotropics were not ordered. The facility did not provide nonpharmacological interventions to Resident # 13 before administering Ativan and did not document the types of behaviors that were present requiring anxiolytic administration as needed. On 01/10/25 at 12:30 PM, a review of the Treatment Administration Record for the resident did not reveal any task that specifically ordered the monitoring of the resident's psychiatric symptoms, including anxiety. On 01/15/25 at 1:33 PM, in an Interview with the Director of Nursing (DON) and the Facility Administrator (NHA) it was revealed that the facility did not monitor Resident #13's behaviors when receiving Anxiolytics and did not perform non-pharmacological interventions before administering psychotropics.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50904 Based on record review and interview with facility staff it was determined that the facility failed to have a system in place to ensure that Geriatric Nursing Assistant (GNA) received education about residents' safety and residents' care after an alleged abuse incident. This was found to be evident for two Geriatric Nursing Assistants (GNA #10 and #37) out of 7 GNAs' reviewed for training records reviewed during this recertification/complaint survey. The findings include: 1)On 01/09/25 at 12:48 PM, a review of GNA #10's employee file revealed that she was hired in July 2023. However, there were no training records for residents' safety and transfer mobility seen for the employee upon hire date and afterward. On 01/09/25 at 12:54 PM, in an interview with the Director of Nursing DON, when she was asked about the training process upon hire, she explained to the surveyor that the education/skills packets are given to the employees, and they take the packets to the employee who is orienting them, and the signed/completed skills packets are put in the new employee file. When she was informed that training on resident safety and mobility transfer for GNA #10 was missing, she stated that she was not a staff at the facility when GNA#10 was employed. On 01/09/25 at 03:57 PM, the Nursing Home Administrator provided a copy of the skills competency and annual in-service training of GNA #10 to the surveyor but there was no record of residents' safety training for the employee. When he was asked for it, he stated that the annual in-service training was the same as the training upon hire and he was informed that resident safety and transfer mobility training was not included in GNA #10's training record. On 01/13/2025 at 8:15 AM, the Nursing Home Administrator and the Director of Nursing were informed that there was no evidence that GNA#10 had any training done on resident safety and transfer mobility. They both agreed that the GNA had no prior training concerning resident safety and transfer mobility. 43096 2) During a review of the facility self-reported incident, MD00191481, on 1/11/25 at 3:06 PM, it was revealed that Resident #261 reported that a GNA hurt him/her leg and put a dirty brief in his/her face on 4/20/23. Further review of the facility's investigation revealed that they conducted head-to-toe assessments, pain assessments, and interviews with residents and staff. The facility noted that GNA #37 cared for Resident #261 while the resident complained about leg pain. GNA #37's statement showed that after she provided care for the resident, the resident complained of leg pain, and a nurse gave the resident medication. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Nursing Home Administrator (NHA) on 1/14/25 at 12:35 PM, he stated that the perpetrator, GNA (#37), was removed from the assignment and the facility provided in-service training for 'timely report' and 'customer service-apologize if pt states our actions caused pain'. However, GNA #37 was not signed for customer service- apologize training. The surveyor reviewed the facility's in-service training record with the NHA. The NHA confirmed that GNA #37 had no training records for the above incident.