STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215241	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Nursing Home Operator, LLC	1601 East Belvedere Avenue Baltimore, MD 21239

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 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 record review, complaint # 2991568 and interviews, it was determined the facility staff failed to report alleged violations related to neglect and/or abuse, including injuries of unknown source with major injuries to the Office of Healthcare Quality as required. This was evident for 1 (Resident #97) of 39 residents records reviewed during the recertification survey process. The findings include: On 04/27/2026 at approximately 11am, a review of complaint #2991568 alleged that Resident #97 was being accused of verbally threatening his/her roommate, with no proof of the alleged abuse. On 04/27/2026 at 2:43 PM, in an interview with Resident #97, the resident reported that he/she was accused of threatening to kill his/her roommate (Resident #166). Resident #97 stated that the staff alleged that Resident #166 reported the alleged threat to the staff and they called the police on him/her; however, Resident #97 denied threatening the roommate (Resident #166). On 4/30/2026 at 11:45 AM, a review of Resident #97's care plan created on 03/24/2026 revealed that Resident #97 had a diagnosis of Mood disturbance related to Depression as evidenced by fluctuations in mood. On 04/30/2026 at 11:54 AM, a review of a change in condition evaluations completed on 04/21/2026 at 11:43 PM revealed that Resident #97 became verbally aggressive toward his/her roommate after accusing the roommate of eating his/her food. It was alleged that Resident #97 stated, I will kill you, in the presence of a staff. The police were called to evaluate the situation. On 04/30/2026 at 12:13 PM, in an interview with Assistant Director of Nursing (ADON) and the Regional Clinical Services Manager, they were asked if the above-mentioned incident was submitted to the Office of Health Care Quality (OHCQ) and the ADON stated no. They were asked what the expectation of the facility was, if a resident threatens to kill another resident. They acknowledged that the facility should have reported the incident to OHCQ.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on a review of facility investigative materials, medical records, and staff interviews, it was determined that the facility failed to thoroughly investigate an injury of unknown origin. This was evident for one (Resident #161) of three residents reviewed during this recertification/complaint survey.The findings include:On 4/30/26 at 7:53 AM, the surveyor reviewed a self-reported incident #340529. The review revealed that on 5/01/25 at approximately 1:00 AM, Resident #161 was found with their head hanging off the side of the bed while their lower body remained on the mattress. The resident sustained a skin tear on the right lateral leg, which required transfer to the hospital and seven superficial Prolene sutures. The facility's internal investigation concluded that because the fall was unwitnessed, the cause could not be determined.Further review of Resident #161's medical record revealed that the resident's most recent Brief Interview for Mental Status (BIMS), dated 4/18/25, resulted in a score of 13 out of 15, indicating intact cognitive function. Despite the resident's intact cognitive status, the facility's investigative packet contained no written statement from Resident #161 regarding the cause of the injury.During an interview on 4/30/26, the Regional Clinical Services Manager (Staff #19) provided a statement from Licensed Practical Nurse (LPN) #23, who performed the initial assessment. LPN #23 claimed the resident did not know what happened because they were asleep.Review of the hospital visit notes dated 5/01/25 revealed a different account. The resident told hospital staff they were standing on the side of the bed when an aide came in to help, and noted they had been sleeping prior to calling for staff assistance.On 5/01/26, these concerns were presented to the Assistant Director of Nursing, the Regional Clinical Services Manager, and the Nursing Home Administrator. The facility leadership validated these findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 complaint investigations, medical record reviews, and staff interviews, it was determined that the facility failed to assess and/or document the onset and management of unusual changes in resident condition. This deficiency was evident for one resident (Resident #153) out of three reviewed for injuries of unknown origin during the recertification/complaint survey.The findings include:On 4/30/26 at 8:00 AM, the surveyor reviewed self-reported incident #2720156. The report indicated that on 1/17/26, Resident #153 underwent an X-ray due to complaints of right hip pain, which revealed an acute fracture of the right femoral neck.At 8:34 AM on 4/30/26, a review of the resident's medical record revealed a Change in Condition note dated 1/17/26 at 1:33 PM. While the note acknowledged the X-ray results and the fracture, the record lacked any prior documentation regarding the resident's pain, including: the specific time of onset for the unusual pain, which staff member performed the initial clinical assessment, the interventions implemented to manage the pain while awaiting the X-ray, and the specific details of the report to the physician prior to the receipt of the X-ray results.During an interview on 4/30/26 at 9:39 AM, the Assistant Director of Nursing (ADON) and the Regional Clinical Nurse Manager reviewed these findings. They validated that there was no documentation of a pain assessment or nursing interventions leading up to the diagnostic imaging.

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(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 - Minimal harm or potential for 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 complaint investigations, medical record reviews, and staff interviews, it was determined that the facility failed to ensure appropriate wound care, timely specialist consultation, and necessary medication adjustments. This was evident of one (Resident #157) out of five residents reviewed for pressure ulcers during the recertification/complaint survey.The findings include:Moisture-Associated Skin Damage (MASD) is an umbrella medical term for skin inflammation, irritation, and erosion (breakdown) caused by prolonged exposure to moisture, such as urine, stool, wound exudate, sweat, or saliva. A stage 2 pressure ulcer is a partial-thickness skin loss involving the epidermis and/or dermis, appearing as a shallow, pink/red, moist, open ulcer or a ruptured/intact blister. On 4/28/26 at 8:09 AM, the surveyor reviewed complaint regarding Resident #157. The review revealed that the complainant submitted on 1/09/26 had concerns regarding Resident #157's care: the resident did not receive appropriate care and acquired a stage 2 bedsore.In a review of Resident #157's medical record on 4/28/26 at 9 AM, it was revealed that the resident admitted on [DATE]. The first skin assessment documented on 9/11/25 showed that he/she had Moisture Associated Skin Damage (MASD) on sacrum area. The follow up skin assessment was documented on 9/15/25 with sacrum skin issue measured as 5.5 X 2.5 X 0.1 (cm) as MASD. However, the wound specialist's documentation dated 9/15/25 stated signing off on patient who remains in the facility. A week later on 9/22/25, skin assessment and wound specialist documented as stage 2 pressure ulcer documented with size of 3.0 X 1.0 X 0.1 (cm).In an interview with Wound Nurse #22 on 5/01/26 at 8:04 AM, she explained the facility's protocol: the admission nurse performs the initial assessment, which the wound nurse then confirms. The wound nurse rounds weekly with a contracted physician and provides daily care. Additionally, Wound Nurse #22 clarified that MASD requires treatment with zinc ointment, which is a medicated treatment that must be ordered by a physician, unlike standard barrier creams.Upon a joint review of the medical record, Wound Nurse #22 confirmed there was no evidence to prove Resident #157 received treatment with zinc ointment between the initial discovery of MASD and its progression to a Stage 2 pressure ulcer. The nurse further acknowledged that the wound physician's note on 9/15/25 indicated the resident was not actually evaluated by the provider during that visit.On 5/01/26, these findings were presented to the Assistant Director of Nursing (ADON). The ADON validated that the facility failed to obtain the necessary treatment orders and specialist oversight required to prevent the MASD from deteriorating into a pressure ulcer.