STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215250	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goodwill Mennonite Home, Inc.	891 Dorsey Hotel Road Grantsville, MD 21536

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48470 Based on record reviews and interviews, it was determined that the facility failed to ensure residents were protected from abuse. This was evident for 1 (Resident #60) of 5 residents reviewed for abuse. The findings include: Resident #60 was admitted to the facility in 2021. The investigation packet for an abuse allegation on the resident, related to MD00216040 was reviewed on 4/7/25 at 9:43 AM. The review revealed that a Geriatric Nursing Assistant (GNA #14) had pinched Resident #60. The facility's Abuse Coordinator was the Social Services Coordinator (Staff #6). Staff #6 was interviewed on 4/7/25 at 1:22 PM. During the interview, Staff #6 reported that abuse was substantiated after the facility's investigation. Staff #6 indicated that the facility was able to substantiate abuse due to reports by GNA #18, who was also providing care to Resident #60 at the time of the allegation. On 4/7/25 at 2:37 PM, the Chief Human Resources Officer (Staff #13) provided documentation to indicate that GNA #14's employment was terminated on 3/27/25. Furthermore, GNA #14 was banned from coming into the vicinity of the facility and from contacting other employees and/or residents. Staff #13 also provided documentation to indicate that GNA #14's abuse allegation was reported to the Maryland Board of Nursing. On 4/10/25 at 10:18 AM, the Director of Nursing (DON) was interviewed. During the interview, the concern was discussed that the facility had failed to protect Resident #60 from abuse. The DON verbalized understanding and acknowledged the concern.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on review of medical records and facility investigation documentation and interviews it was determined that the facility failed to follow requirements for reporting incidents to the State Survey Agency. This was found to be evident for 5 (Resident #30, # 76, #60, #26, and #160) out of 5 residents reviewed for potential abuse. The findings include: 1) Review of Resident #30's medical record on 4/8/25 revealed the resident has a diagnosis of Alzheimer's dementia with severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. The resident had a current order, in effect since 7/31/24, for 2 staff to provide care at all times. The resident also had a current order, in effect since 8/13/24, for the use of a Stander with assist of 2 for transfers. On 4/9/25 review a progress note, dated 3/26/25 at 6:24 AM, revealed that the geriatric nursing assistant (GNA) reported several bruises to the the resident's legs and one to the resident's wrist. The bruises to the legs included: right inner kneecap bruise of 3 X 2 cm; right outer kneecap is 3.5 x 3.0 cm; right lower knee is 1 x 1cm; right shin is 1.3 X 1cm; left upper shin bruise is 5 x 3 cm and left lower shin bruise is 8 x 4 cm; and the left outer wrist bruise was 1.3 X 1 cm. The progress note also indicated the bruises to the legs line up with the stander lift and the discoloration to the left wrist lines up with the dining room table. No documentation was found in the medical record to indicate the resident had sustained a recent fall or other incident to account for the appearance of the six bruises on 3/26/25. The survey agency did not have a facility reported incident report related to Resident #30 for 2025. On 4/9/25 at 6:36 PM surveyor discussed the bruises with the Assistant Director of Nursing (ADON) #8 who reported there may be additional documentation contained in the risk management report and indicated she would provide the report for review. Surveyor then reviewed the concern that the survey agency did not have a facility report related to the bruises. On 4/10/25 review of the risk management report revealed the resident was unable to give a description regarding the bruising. On 4/10/25 01:13 PM the Surveyor reviewed with the Director of Nursing the concern regarding failure to report the multiple bruises to the state survey and certification office. As of time of survey exit on 4/11/25 at 12:15 PM no documentation was provided to indicate these injuries were reported to the state survey and certification office. 45139 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) 4/3/25 at 9:00 AM Resident # 76's, a long-term resident of the facility, medical records were reviewed. The review revealed a note dated 3/12/2025 documenting that Resident #76 had a new purple blue in color skin issue. However, there was no documentation on what caused the skin issue. On 4/07/25 at 11:25 AM the Assistant Director of Nursing ADON, (Staff #10) provided an Incident report for the above injury. On 4/7/25 at 11:30 AM a review of the incident report revealed the conclusion of the investigation was that Resident #76 bumped hip when transferring to wheelchair. In addition, the incident report documented that Resident #76 was verbally reminded to be cautious when going to the wheelchair. Continued review of the incident report failed to determine how the injury happened. On 4/09/25 11:31 AM a review of MDS annual Review dated 11/17/2024 indicated that Resident #76 was unable to transfer her/his self from the bed to the wheelchair or from the wheelchair to the toilet without substantial help from the staff. On 4/10/25 at 8:41 AM geriatric nursing assistant (Staff #26) was interviewed. During the interview she reported Resident #76 and is unable to transfer her/himself from the bed to the wheelchair or the wheelchair to the toilet without staff assistance. On 4/7/25 at 11:54 AM The ADON staff #10 reported that she was responsible for investigating all injuries. She reported that injuries of unknown origin are not reported to the State Agency if she could find a reasonable explanation for the injury. She reported that she did not need to collaborate evidence or statements to determine the origin of the injury. On 4/10/25 at 11:57 AM The Social Service Coordinator (Staff #6) was interviewed. Staff #6 reported that she is responsible for submitting all reportable injuries to the appropriate state agency. She confirmed that she did not report the injury of Resident #76. In addition, she reported that the facility did not submit any reports to the appropriate state agency during the years of 2023 and 2024. On 4/10/25 at 1:33 PM the above concerns were discussed with the Director of Nursing (DON). No additional information was provided. 48470 3) Resident #60 had been residing in the facility since 2021. The investigation packet of a facility reported incident (FRI) related to MD00216040, regarding an allegation of abuse, was reviewed on 4/7/25 at 9:43 AM. The incident alleged that Geriatric Nursing Assistant (GNA #14) had pinched Resident #60 while providing care. Further review of the investigation packet revealed that the incident was first reported to Licensed practical Nurse (LPN #24) on 3/23/25 at 12:19 PM, who then reported to the facility's abuse coordinator (Staff #6) on 3/23/25 at 12:20 PM. The review also stated that the initial report was sent to the state survey agency on 3/24/25 at 4:03 PM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff #6 was interviewed on 4/7/25 at 1:22 PM. During the interview, Staff #6 reported her process when an allegation of abuse is made including reporting to the state survey agency immediately but no later than 2 hours. Staff #6 acknowledged that the FRI related to MD00216040 was reported late. She indicated that when she read the instructions on the initial report, she informed the facility and confirmed that they were late in reporting and stated, I informed our facility that we were negligent in reporting the incident. On 4/7/25 at 4:26 PM, the facility's abuse policy was reviewed and indicated that all allegations of abuse should be reported immediately but no later than two hours to law enforcement, Office of Health Care Quality (OHCQ), and Ombudsman. On 4/10/25 at 10:18 AM, the concern was discussed with the Director of Nursing (DON). The DON reported that she was already aware that the facility was late to report the incident of abuse related to MD00216040. 51900 4a) Resident #26 has a history of dementia [impaired memory, language, and problem solving] and physical impairments requiring staff to provide total assistance when moving the resident and providing daily care. On 4/7/25 at approximately 11:00 AM, Surveyor review of Resident #26's skin evaluation assessment note dated 12/7/24 revealed that the resident had acquired an injury as noted: Location: Right eyelid. Issue type: Bruising. Wound acquired in-house. Wound is new. Length (cm): 1, Width (cm): 0.5. On 4/08/25 at 10:00 AM the surveyor reviewed the investigation report dated 12/7/24, which revealed: Nursing description: 1cm x 1 cm light blue discoloration noted to the right lateral eye upper lid. There was no record of the facility reporting the incident to the state regulatory agency. 4b) Resident #160 was admitted to the facility on [DATE] for care related to dementia. The surveyor reviewed complaint MD00195657 which expressed concern that Resident #160 had multiple bruises. On 4/08/25 at 2:15 PM, surveyor review of Resident #160's medical record revealed the following: On 7/6/23, 7/18/23, and 7/20/23, administrative progress notes stated that Resident #160 had bruises. On 7/24/23- Nursing Note- Geriatric Nursing Assistant notified this nurse during morning care of a bruised area to the top of left foot and under 2nd 3rd and 4th toes, bruise bluish purple in color, 4.5cm x 2.0cm. On 8/4/23: Nursing Note: Noted deep purple bruise to right foot/toes, 3x2cm. On 4/8/25 at 10:00 AM, the surveyor was provided with copies of two injury investigation reports for Resident #160. One was dated 7/24/23 and the other dated 8/4/23. There was no record of the facility reporting the incidents to the state regulatory agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/08/25 at 1:00 PM, the surveyor reviewed the facility policy and procedure titled Abuse Policy dated March 2025 which stated that All alleged incidents of verbal, sexual, physical, and mental abuse; neglect, crime, injury of unknown source; and misappropriation of resident property shall immediately be reported to the Director of Nursing (DON) and the Administrator. The DON will promptly report the alleged abuse to the Social Services Coordinator who is responsible for ensuring that the incident is reported within the appropriate time frame of discovery as listed below: - Serious Bodily Injury or Abuse-reported within 2 hours (to law enforcement, Office of Health Care Quality, and to the Ombudsman. - All others within 24 hours. The facility policy doesn't reflect the state regulation that requires that all injuries of unknown origin are reported within two hours. On 4/08/25 at 4:15 PM, the surveyor interviewed Assistant Director of Nursing (ADON #10), who confirmed that she is responsible for investigating unusual events related to resident care. When asked to describe her process for investigating injuries of unknown origin or unexplained bruising, she stated that her approach includes obtaining and reviewing staff statements, performing a resident assessment, conducting a record review, and asking other residents if they saw anything. When specifically asked whether injuries of unknown origin should be reported, ADON #10 responded, I would figure out if it was abuse and report it. However, when the surveyor requested documentation confirming that such incidents had been reported, ADON #10 stated, I haven't done it, because I haven't received a report of an injury of unknown origin. The surveyor then expressed concern that the bruising of unknown origin for Resident's #26 and #160 had not been reported to the appropriate regulatory agency. In response, ADON #10 confirmed that she had no additional documentation related to the incident. On 4/10/25 at 1:05 PM, the surveyor discussed concerns with the Director of Nursing regarding the facility's failure to report injuries of unknown origin. Specifically, the bruising observed on Resident #26 and Resident #160 had not been reported, and the facility's policy did not align with regulatory requirements for reporting such incidents. The Director of Nursing agreed that the bruising should have been reported and acknowledged that the incidents should have been reported within two hours, as required.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 16218 Based on review of medical records, facility investigation documentation, and interviews it was determined that the facility failed to ensure injuries of unknown origin were thoroughly investigated. This was found to be evident for 2(Resident #30 and #26) out of 5 residents reviewed for potential abuse. The findings include: 1) Review of Resident #30's medical record on 4/8/25 revealed the resident had a diagnosis of Alzheimer's dementia with severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. The resident had a current order, in effect since 7/31/24, for 2 staff to provide care at all times. The resident also had a current order, in effect since 8/13/24, for the use of a Stander with assist of 2 for transfers. On 4/9/25 review a progress note, dated 3/26/25 at 6:24 AM, revealed that the geriatric nursing assistant (GNA) reported several bruises to the the resident's legs and one to the resident's wrist. The bruises to the legs included: right inner kneecap bruise of 3 X 2 cm; right outer kneecap is 3.5 x 3.0 cm; right lower knee is 1 x 1 cm; right shin is 1.3 X 1 cm; left upper shin bruise is 5 x 3 cm and left lower shin bruise is 8 x 4 cm; and the left outer wrist bruise was 1.3 X 1 cm. The progress note also indicates the bruises to the legs line up with the stander lift and the discoloration to the left wrist lines up with the dining room table. On 4/9/25 at 6:36 PM the Assistant Director of Nursing (ADON #8) indicated there was a risk management report that she would provide for surveyor review regarding the resident bruising. On 4/10/25 review of the risk management report revealed the resident was unable to give a description regarding the bruising. In the section of the report for statements, four staff were listed with the shifts they had worked from 3/24 night shift through 3/25 night shift. The statement from the staff who worked the 3/25 night shift was dated 3/26/25, and consisted of Noticed multiple discolorations while giving care and reported to my nurse. The entirety of the statements, dated 3/28/25, from the three staff that worked with the resident in the three shifts prior to the identification of the bruising consisted of : didn't notice. No documentation was found in this report to indicate that these three staff were asked any questions regarding events that may have contributed to the bruising. Further review of the risk management report revealed the following statements: Areas bumped into stander lift when being transferred; and Resident bumped left wrist on edge of table in dining room producing bruise. On 4/10/25 at 12:26 PM surveyor reviewed the risk management report with the Director of Nursing (DON). When asked how they came to the conclusions about the source of the bruising, the DON stated we would have to ask ADON #10. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/25 at approximately 12:46 PM interview with ADON #10 revealed the ADON did interview staff, including asking if they had two staff to assist with care. Surveyor reviewed the concern that the investigation documentation provided failed to support that a thorough investigation had been conducted. On 4/10/25 01:13 PM Surveyor reviewed with the Director of Nursing the concern regarding failure to have documentation of a thorough investigation. 51900 2) Resident #26 has a history of dementia [impaired memory, language, and problem solving] and physical impairments requiring staff to provide total assistance when moving the resident and providing daily care. On 4/7/25 at approximately 11:00 AM, Surveyor review of Resident #26's skin evaluation assessment note dated 12/7/24 revealed that the resident had acquired an injury as noted below: Location: Right eyelid. Issue type: Bruising. Wound acquired in-house. Wound is new. Length (cm): 1 Width (cm): 0.5 The note did not indicate how the bruise to the right eyelid occurred. On 4/08/25 at 10:00 AM the surveyor reviewed the investigation report dated 12/7/24, which revealed: *Nursing description: 1cm x 1 cm light blue discoloration noted to the right lateral eye upper lid, probably occurred with transfer with the hoyer lift pad. *According to staff statements, three out of four individuals reported that they did not notice the bruise, while one stated they found and documented it-though no additional details were provided. *The final investigation conclusion dated 1/7/25 written by Assistant Director of Nursing (ADON#10) stated that the bruise was caused by the hoyer lift. On 4/08/25 at 4:15 PM, the surveyor interviewed ADON #10, who confirmed she conducts investigations into unusual events related to resident care. When asked about her process for investigating injuries of unknown origin or unexplained bruising, she stated that her process includes obtaining and reviewing staff statements, performing a resident assessment, conducting a record review, and asking other residents if they saw anything. She then summarized the findings. The surveyor asked if she interviews and assesses other residents in cases of unknown-origin injuries, and she replied, oh, yes. However, when asked for documentation of such investigations, she stated, I haven't done it, because I haven't received a report of an injury of unknown origin. Regarding whether a bruise on the eye is considered normal, she responded, are you talking about Resident #26? and explained she did not work at the facility at the time of the incident; a previous nurse initiated the investigation, but acknowledged she was aware of the incident and that she did complete the final note concerning the investigation about the bruise to the resident's eye. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor then expressed concerns that the investigation failed to include evidence to support how the determination was made that the bruise was caused by the hoyer lift. ADON #10 stated that she had no additional documentation about this incident. On 4/10/25 at 1:05 PM, the surveyor discussed concerns with the Director of Nursing regarding the facility's failure to conduct a thorough investigation for injuries of unknown origin. Specifically, the facility did not document a thorough investigation into the cause of the bruising to Resident #26's right eye. She agreed that the facility needed to do a more in depth investigation. On 4/10/25 at 4:50 PM, Surveyor review of facility Policy and Procedure titled Injuries of Unknown Source revealed the following: An injury should be classified as an injury of an unknown source when all of the following criteria are met: The source of the injury was not observed, the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury. The Procedure section of the policy states that the facility will obtain written statements from any GNAs assigned to the resident and if no cause is evident, the nurse is to attempt two phone calls to each GNA working on the past three shifts, if necessary, to determine the cause of the injury. The nurse will obtain the GNA's statement. Injuries of unknown sources will be tracked by Quality Assurance to determine potential causes and preventions. On 4/10/25 at 5:05 PM, the surveyor interviewed the Quality Assurance Nurse (Staff #15) and asked if incidents involving injuries of unknown origin are discussed in the quality meetings. She stated that ADON #10 does bring concerns, but was unable to provide any additional clarification about any changes that may have been made to prevent future occurrences or improve the investigations related to the incidents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45139 Based on interview, observation and record review it was determined that the facility failed to 1) ensure that a resident received the correct cream/protectant ordered by a physician, and 2) protect residents from injury. This was evident for 2 (Resident # 5 and #160) out of 5 residents reviewed for non-pressure skin conditions. The findings include: 1) On 4/2/25 at 10:16 AM an interview was conducted with Resident #5, a long-term resident residing in the dementia care unit. During the interview s/he complained that s/he had an itchy back which was being treated with a cream kept by her/his bedside. On 4/2/25 at 10:17 AM a tube of Dimethicone skin protectant was observed next to the Resident #5. On 4/9/25 a review of Resident #5 physician orders failed to reveal an order for Dimethicone skin protectant. On 4/9/25 4:41 PM during an interview with the Assistant Director of Nursing (Staff #8) she confirmed that Resident #5 did not have an order for the Dimethicone skin protectant. Staff #8 reported that Resident #5 had a different cream ordered. Staff # 8 reported that she had started an in-service to educate the staff on how to ensure a resident received the correct lotion per physician's orders. On 4/9/25 an observation of the dementia unit revealed an educational document dated 4/9/25, with an attached education sign in sheet. The educational documents included the following instructions: Residents can only have creams that are ordered at the bedside. We went through and had to pull a lot of creams that we found without orders. 51900 2) Resident #160 was admitted to the facility on [DATE] for care related to dementia. The surveyor reviewed complaint MD00195657 which expressed concern that Resident #160 had multiple bruises. * 4/08/25 at 2:15 PM, surveyor review of Resident #160's medical record revealed the following: * 6/27/23- Admission skin evaluation revealed that the resident's skin was within normal limits with no bruising noted. * 7/6/23, 7/18/23, and 7/20/23, there were three treatment administration notes that stated that the resident had bruising: Orders: Administration Note: Observe closely for significant side effects of Anticoagulant medication including discolored urine, black tarry stools, sudden severe headache, nausea or vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status or vital signs, shortness of breath, nose bleeds every shift. Findings-Bruising * 7/8/23- Skin only evaluation- Skin warm and dry, skin color within normal limits, turgor normal. The skin evaluation didn't mention the bruising noted on 7/6/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 7/22/23- Skin Only Evaluation- Skin warm and dry, skin color within normal limits, turgor normal. No Skin Issues. The skin evaluation didn ' t mention the bruising that was noted on the 7/18/23 or 7/20/23 Administration notes. * 7/24/23- Nursing Note- Geriatric Nursing Assistant notified this nurse during morning care of bruised area to top of left foot and under 2nd 3rd and 4th toes, bruise bluish purple in color, 4.5cm x 2.0cm, denies pain, moves toes without difficulty, ambulates without difficulty, usual edema noted, lines up with bar at the bottom of tray table, Doctor notified and ordered an x-ray of left foot. * 8/4/23: Nursing Note: Noted deep purple bruise to right foot/toes, 3x2cm, lines up with bottom of tray table, staff reported to this nurse that resident has been seen sliding feet under and kicking tray table. Range of Motion within normal limits, no complaint of pain to the area. Ambulating with no concerns. Doctor is aware and provided no new orders. On 4/8/25 at 10:00 AM, the surveyor was provided with copies of two injury investigation reports for Resident #160. One was dated 7/24/23 and the other dated 8/4/23. Surveyor review of the injury investigation report dated 7/24/23 revealed that the report stated the following: The resident's foot was assessed for pain, and an X-ray showed no acute fracture. The injury was consistent with the resident striking their foot on the bottom of a tray table commonly positioned in front of them. The resident is at an increased risk for bruising due to Plavix [blood thinner] use. Staff were advised to keep the area around feet clear and to apply protective footwear when the resident is out of bed. However, a review of Resident #160's July 2023 physician orders showed no documentation of instructions to apply protective footwear or to maintain a clutter-free area around their feet. Review of injury investigation report dated 8/4/23 stated: Area and pain assessed. Bruising occurred as a result of the resident kicking tray table away from self. Protective footwear placed on resident and tray table placed away from resident to avoid further injury. Review of the Resident #160's August 2023 physician orders do not show evidence of orders to apply protective footwear or keep the area clear around the resident's feet. On 4/08/25 at 4:15 PM, the surveyor interviewed Assistant Director of Nursing (ADON #10), who confirmed she conducted investigations into unusual events related to resident care. When asked about her process for investigating injuries for unexplained bruising, she stated that the goal is to figure out if it was abuse and report it, if the injury can't be explained. When asked if she expects physician orders to be placed for interventions, she responded, yes, absolutely. The surveyor then presented nursing chart notes indicating that Resident #160 had documented bruising on 7/6/23, 7/18/23, and 7/20/23. However, skin-only assessments on 7/8/23 and 7/22/23 did not reflect any bruising. The surveyor expressed concern that Resident #160 was later found to have significant bruises to their left foot on 7/24/23 and then to the right foot on 8/4/23, with no evidence that the interventions suggested on the incident report had been implemented to prevent further harm. ADON #10 confirmed that the bruising should have been documented on the skin assessment sheets and agreed that the expectation would be to have orders for Resident #160 to have protective footwear and a clutter-free environment around her feet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215250	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goodwill Mennonite Home, Inc.	891 Dorsey Hotel Road Grantsville, MD 21536

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/25 at 1:05 PM, the surveyor discussed concerns with the Director of Nursing regarding the facility's failure to protect the resident from bruising and injury. Specifically, the facility did not implement interventions to prevent recurrence. She agreed that the interventions should have been implemented.