STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215265	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Ridge Nursing and Assisted Living Center	710 Obrecht Road Sykesville, MD 21784

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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 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 review of facility documents and staff interview it was determined the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made. This was evident for 2 (#3, #1) of 3 residents reviewed for an injury of unknown source and 1 (#2) of 1 residents reviewed for misappropriation of resident property.The findings include:On 12/4/25 at approximately 12:15 PM, a review of facility reported incident, 263516, documented that on 10/5/25 at 6:15 AM, Resident #3 was observed to have bruising and swelling of his/her left eye that was an injury of unknown origin.The facility's investigation documented that staff became aware of the incident on 10/5/25 at 6:15 AM. Further review of the facility's documentation revealed an email confirmation that documented the facility's initial self-report was sent to the State Agency on 10/5/25 at 11:51 AM.The facility failed to report the injury of unknown source immediately, but not later than 2 hours after the becoming aware of injury.The concerns with late reporting an injury of unknown source was discussed with the Nursing Home Administrator (NHA) and Staff #17, Registered Nurse (RN) Unit Manger (UM). The NHA acknowledged the concerns and offered no further comments at that time.2) On 12/8/25 at 1:33 PM, a review of facility reported incident, 2594806 documented that on 8/19/25, around 8:30 AM, the nurse observed Resident #1 with a bruise on his/her right forehead that was an injury of unknown source.The facility's investigation documented that staff became aware of the incident on 8/19/25 at 8:30 AM. Further review of the facility's documentation revealed an email confirmation that documented the facility's initial self-report was sent to the State Agency on 8/19/25 at 11:31 AM.The facility failed to report an injury of unknown source immediately, but not later than 2 hours after the allegation was made.3) On 12/10/25 at , a review of facility reported incident, 2583979, documented that on 8/6/25 at 4:00 PM, a discrepancy between Resident #2's Medication Administration Record (MAR), the narcotic log sheet and the number of pills administered alleging misappropriation of Resident #1's narcotic medication.The facility's investigation documented that staff became aware of the alleged misappropriation of a resident's narcotics on 8/6/25 at 4:00 PM. Further review of the facility's documentation revealed an email confirmation that documented the facility's initial self-report was sent to the State Agency on 8/7/25 at 3:59 PM.The facility failed to report an allegation of misappropriation of a resident's medication immediately, but not later than 2 hours after the allegation was made.The concerns with the failing to ensure that the alleged violations involving injuries of unknown source and misappropriation of resident property were reported timely were discussed with the NHA on 12/10/25 at 3:00 PM. The NHA acknowledged the concerns with late reporting and no further comments were offered at that time.

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility and medical records and interview with staff it was determined the facility staff failed to provide adequate supervision to prevent a cognitively impaired resident from eloping from the facility. This was evident for 1 (#7) of 2 residents reviewed for accidents.The findings include:Review of Resident #7's medical record on 12/4/25 at 1:38 PM revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included but were not limited to mild neurocognitive disorder due to known physiological condition with behavioral disturbance, cognitive communication deficit and other sequelae of cerebral infarction. Resident #7 ambulated independently and without the use of assistive devices. The resident had 2 physician certificates indicating s/he lacked capacity to make medical decisions due to Cognitive Impairment. An initial elopement risk assessment dated [DATE] indicated s/he was not an elopement risk. A Brief Interview for Mental Status (BIMS) assessment is a tool used to identify a resident's cognitive function levels, a score of 8-12 indicates moderate impairment in thinking and memory; 0-7 indicates severe impairment.A BIMS assessment was conducted on 8/13/25 at 9:37 AM by Therapy. The assessment indicated Resident #7's BIMS score was 11/15. Another BIMS assessment was conducted later the same day, at 5:25 PM by Social Service. Resident #7's score at that time was 7/15. Nursing progress notes from 8/13/25 12:31 PM - 8/16/25 included that Resident #7 did not obey commands, had behaviors such as refusing care and medications, agitation, wandering at night and identified safety concerns including exit seeking, fall risk and wandering. However, no measures were put in place to address these behaviors. An SBAR summary note dated 8/17/25 09:00 identified the Situation: patient eloped. It described that the resident woke up around 7:00 AM, was fully dressed with bags packed and attempted to leave to go home. S/he was redirected, reoriented to place. The oncoming supervisor was notified. The note indicated that at 7:30 AM Resident #7 attempted to break a window to elope, was agitated and cursed at staff. A GNA was asked to watch the resident. The GNA alerted the nursing supervisor that the resident was attempting to elope. Around 8:55 AM the nurse was alerted that staff could not find Resident #7.Facility reported incident #2592377 was reviewed on 12/4/25 at 11:34 AM. The report revealed that Resident #7 eloped from the facility on 8/17/25 at approximately 8:50 AM. The facility staff began their search protocol, and the police were notified. The police located the resident at 9:39 AM at a gas station approximately 3.5 miles away. S/he was positively identified by the facility and taken to the hospital for an evaluation. S/he returned, unharmed and at his/her baseline, to the facility at 10:00 PM on 8/17/25.The facility investigated and determined through interviews and review of video footage that Resident #7 walked to the elevator with 2 tote bags and rode the elevator to the lower level with a laundry aide. Once on the lower level, Resident #7 went to the kitchen where a dietary aide assumed s/he was a visitor trying to get to his/her car parked behind the building and the dietary aide escorted Resident #7 out a building exit door. From their investigation of the incident the facility concluded that facility staff (laundry and dietary) failed to verify the identity of an exit seeking resident, mistook him/her as a visitor and let him/her out of the building. In an interview on 12/9/25 at 11:07 AM, Staff #1 confirmed she was the nursing supervisor working on the morning of 8/17/25. She indicated it was the beginning of the day shift and she was in the process of getting everything organized for the day. Resident #7 spoke to her. Staff #1 stated S/he didn't tell me s/he wanted to leave, just that s/he wanted to go. S/he was calm. Another nurse reported to her that Resident #7 did something to the window so I watched him/her for a little while and s/he was calm. She indicated that she went around to all the staff to give them a heads-up regarding Resident #7's behavior. She asked the nurse to call the on-call provider to inform them of Resident #7's behavior. She indicated she wanted to make sure the receptionist knew what the resident looked like, so they went together to look at the resident and discovered s/he was gone. She indicated that it transpired very fast and that when staff went outside to search, a gentleman across the street reported he was outside and witnessed someone resembling Resident #7's description getting into a truck. The police were immediately notified. Staff #1 indicated that Resident #7 was very put together and could have been easily mistaken for a visitor. On 12/9/25 at 11:32 AM Staff #5, a staffing agency Geriatric Nursing Assistant (GNA), revealed that when she started her shift on the morning of 8/17/25 Resident #7 was just walking around, went to the doors several times and started saying s/he wanted to go out. The supervisor was notified. Staff #5 indicated that she sat with Resident #7 in the dayroom for about 30-45 minutes to keep an eye on him/her. She indicated that Resident #7 calmed down, wasn't talking about going out and remained calm. Other staff were around. She

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of Geriatric Nursing Assistant (GNA) personnel files and staff interview, it was determined that the facility failed to conduct yearly performance reviews at least every 12 months. This was found to be evident for 4 (#8, #13, #14, #15) of 4 GNA employee files reviewed.The findings include:Performance appraisals are to be completed at least every 12 months to identify in-service education needed to address competencies of the geriatric nursing assistants. During a complaint survey, a review of Geriatric Nursing Assistant personnel files failed to reveal evidence of yearly evaluations. On 12/11/25 at 1:18 PM the surveyor requested the yearly performance reviews for 4 GNAs (#8, #13, #14, #15).On 12/11/25 at 2:20 PM, Staff #12, Human Resources reported to surveyor that s/he was unable to find any GNA performance reviews.On 12/11/25 at approximately 6:00 PM, the above concerns were discussed with Staff #6, Corporate Registered Nurse (RN). The Corporate RN acknowledged the concerns at that time and confirmed there was no evidence to indicate annual performance reviews of the GNAs had been conducted.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility files and interview with staff it was determined the facility staff failed to ensure all direct care staff received mandatory training for Effective Communication.This was evident for 4 (#8, #9, #10, and #11) of 4 direct care staff reviewed for Training Requirements during the extended survey.The findings include:Six employee files were reviewed for education and training on 12/11/25 at 9:30 AM. The files for Geriatric Nursing Assistants (GNA) Staff #8, #9 and #10 and Staff #11 a Registered Nurse (RN) failed to reveal that they received mandatory training for Effective Communication.On 12/11/25 at approximately 11:30 AM, Staff #12 Human Resources (HR) Director was made aware of the above findings. Despite several attempts she was unable to produce evidence that Effective Communication education was provided to the above staff members as required.On 12/11/25 at 11:57 AM, Staff #6 the Corporate Nurse was made aware of these findings. After attempting to obtain the records and speaking with Staff #12, she informed the surveyor that the education records were not systematically maintained, and she was unable to determine if and when the education was provided.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of facility files and interview with staff it was determined the facility staff failed to ensure all staff received mandatory training on the elements and goals of the Quality Assurance Performance Improvement (QAPI) program.This was evident for 4 (#8, #10, #3 and #4) of 6 staff reviewed for Training Requirements during the extended survey.The findings include:Six employee files were reviewed for education and training on 12/11/25 at 9:30 AM. The files for Staff #8 and #10 Geriatric Nursing Assistants (GNA's), Staff #3 a Dietary Aide and Staff #4 a [NAME] failed to reveal they received the mandatory training on the elements and goals of the facility's QAPI program.Staff #12, the Human Resources (HR) Director, was made aware of the above findings on 12/11/25 at approximately 11:30 AM. Despite several attempts she was unable to produce evidence that the training was provided as required. Staff #6 the Corporate Nurse was made aware of these findings at 11:57 AM on 12/11/25. She spoke with Staff #12 and attempted to locate the education records. However, she informed the surveyor that the education records were not systematically maintained, and she was unable to determine if and when the education was provided.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on review of facility files and interviews with staff it was determined the facility staff failed to ensure all staff received mandatory training for the Infection Control program. This was evident for 1 (#4) of 6 staff reviewed Training Requirements during the extended survey.The findings include:Employee files for 6 facility staff were reviewed for education and training on 12/11/25 at 9:30 AM. No documentation was found to indicate that Staff #4 a [NAME] received training for the facility's Infection Control program as required. Staff #12, the Human Resources (HR) Director, was made aware of the above findings on 12/11/25 at approximately 11:30 AM. Despite several attempts she was unable to produce evidence that the training was provided to Staff #4.Staff #6 the Corporate Nurse was made aware of these findings at 11:57 AM on 12/11/25. She indicated that she spoke with Staff #12 and attempted to locate the records herself. However, the education records were not systematically maintained, and she was unable to determine if and when the education was provided.