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	06/22/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record reviews, it was determined that the facility failed to to provide necessary services to maintain good personal hygiene for dependent Residents timely. This was evident for 2 (Resident #74 & #68) of 5 residents reviewed for activities of daily living during the annual survey.The findings include:Activities of daily living (ADL) are tasks we do to stay alive and well, and include eating, going to the bathroom, bathing, transferring etc.1) On 06/16/2026 at approximately 8:20 AM the surveyor observed that Resident #74 call light was on. LPN #20 was in the hallway passing medication. The surveyor waited 20 minutes to see if anyone would respond to the call light, but no one did. The surveyor went into the resident's room to see if they were ok. Resident #74 said it's been 24 minutes since she put on their call light and no one had shown up and s/he wanted to go to the bathroom and be cleaned up. The surveyor told the resident that she would go look for their aide. The surveyor approached LPN #20 and told her the resident needed help and asked if the aide was available, she said the aide was in another resident's room providing care. The MDS Coordinator-#12 was seen going into Resident #74's room. She told the resident she would get someone to help them. The surveyor went back to check on the resident 30 minutes later and asked if help had been provided. The resident told the surveyor that it took 40 minutes before someone came to provide care. In an interview with the unit manager #16 on 06/16/2026 at 3:26 PM, she was asked about call bell response time. She said call lights are to be responded to immediately to see if the resident needed immediate attention. She was made aware that the surveyor observed the call light for 20 minutes without anyone responding even though the LPN #20 was in the hallway passing medications. She said the LPN should have popped in to see what the resident needed and to make sure they were not in distress. She said she will follow up. On 06/16/2026 at 4:22 PM the unit manager told the surveyor that she went to see the resident and resident confirmed that she waited 45 minutes before help could be provided. The unit manager said she will put a concern form in and provide education and in-services to staff regarding call bell response time and will follow up with LPN #20. On 06/18/2026 at 9:19 AM The Director of Nursing (DON) was made aware of the above concern. 2) On 6/22/26 at 7:19 AM, the surveyor reviewed complaint #2728155. The complaint alleged that Resident #68 sat in urine saturated diapers for hours. Next the surveyor reviewed Resident #68's care plan. A care plan for Activity of Daily Living (ADL) selfcare performance deficit was created on 1/27/26. One of the interventions was to have a toilet schedule at least every 2 hours. Additionally, a care plan was created stating Resident #68 had bladder incontinence. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed Resident #68's admission Minimum Data Set (MDS) assessment. The review revealed that Resident #68 was coded dependent or toileting hygiene. On 6/22/26 at 9:46 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor requested documentation that toileting/incontinent care was provided to Resident #68 every 2 hours as identified as needed in his/her care plan. On 6/22/26 at 10:55 AM, the surveyor conducted a follow-up interview with the DON. The DON provided a TASK flowsheets for January 2026 and February 2025. Staff documented every shift (except on day shift on 2/24/26 & 2/25/26) that Resident #68 was incontinent, however there was no indication as to how many times in the shift Resident #68 was provided incontinent cares. The surveyor reviewed the concern that there was no documentation to indicate Resident #68 was provided with incontinent care every 2 hours per his/her assessed need in the care plan.

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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. Based on observations, interviews, review of facility investigations and medical record review, it was determined that the facility failed to adequately supervise Resident #34 from behaviors that subjected him/her to the risk of serious injuries. This was found to be evident for 1 (Resident #34) of 3 residents reviewed for behaviors. The Maryland Office of Health Care Quality (OHCQ) determined that the concern met the Federal definition of Immediate Jeopardy, and the facility was notified in writing of this determination at 2 PM on 6/17/26. The findings include:On 6/17/26 at 8:30 AM, the surveyor reviewed the Facility Reported Incident (FRI) #2686663 pertaining to an injury of unknown origin noted on Resident #34. The incident was reported to OHCQ on 12/05/25. On review of the progress notes from the date of the discovery of the injury of unknown origin, 11/30/25, it was noted that Resident #34, remains alert with episodes of confusion. Was seen walking around the unit in circles. Was put to bed x2, was not effective. Around 7:40 pm, the resident was seen with a hematoma to the forehead and a laceration to the bridge of the nose. The investigation concluded that Resident #34's injury probably resulted from the resident's bumping into a wall or door when ambulating independently and history of unwitnessed falls. Next, the surveyor reviewed the unwitnessed injury care plan created on 11/30/25. One of the interventions stated to ensure the environment was safe, and another was to implement increased rounding/observation as needed. No additional detail was given as to how and when this should be done. On further review of Resident #34's medical record, a note written on 12/10/25 by Registered Nurse (RN) #5 and documented at 11:04 AM, Resident # 34 was seen on the floor after hearing a loud crash. It was also noted that Resident #34 was observed walking in the hallway 5 minutes prior to fall. This was the second fall in 10 days. A note written on 12/14/25, shortly after the fall was reviewed. The note was written by Registered Nurse (RN) #26 and documented Resident #34 demonstrated limited ability to understand communication and was intermittently able to be understood. It further stated that Resident #34 did not follow simple commands, was not redirectable, was observed wandering in the unit without awareness of environmental hazards, and that memory impairment and confusion were noted. Additionally, RN #26 documented that Resident 34's gait was unsteady with imbalance and noted Resident #34 was at increased risk for falls and would be monitored closely for safety. Resident #34's insomnia, Urinary Tract Infection (UTI), pain and increased anxiety were addressed with an order to monitor behavior every shift for the presence of agitation, anxiety, depressed, hallucinations, restlessness, refusal of care and other, however, no additional orders or care plan updates were made, to indicate how Resident #34 would be monitored closely for safety for wandering or unsteady gait. The surveyor reviewed a progress note written by Registered Nurse (RN) #5 on 2/8/2026 at 10:24 AM. The progress note documented that Resident #34 was observed leaning against the wall close to the dining room, lost consciousness for a few seconds, and fell backwards and hit his/her head on the floor. The actual fall care plan was reviewed and an update was done on 2/9/26 and stated, witnessed fall in dining room, resident transferred to the Emergency Department (ED) for evaluation of hematoma and returned within 24 hours. However, no new interventions were added. Resident #34's activities of daily living care interventions last updated on 4/16/25 indicated that Resident #34 walked on the unit independently but also needed hands-on guidance at times for appropriate movement on the unit. An additional intervention stated, to provide increased assistance if gait is unsteady. Resident #34's gait was documented unstable from the previous fall and the interventions were not updated. The surveyor reviewed a progress note written after a history and physical on 4/24/26 by Physician #27 that documented Resident #34's gait was unstable and that Resident #34 had a history of falls and was a fall risk. The note stated ambulatory wandering was addressed with the use of environmental supervision and fall prevention included safe footwear and continued staff-supervised ambulation. Next the surveyor reviewed a note written by the Social Work Director (SWD) #8 written on 4/10/26 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 8:33 AM. The note stated that Resident #34 needed 24/7 care, required supervision and had recently been put on a Wander Guard system to prevent risk of wandering off the unit. The note also noted that Resident #34 was able to feed his/herself but will also try to consume non food items if not monitored or will eat food off of other's plates. It further stated that Resident #34 was non verbal, no longer able to communicate, was a fall risk and wandered the unit often. Next the surveyor reviewed the care plan for Resident #34 that stated, he/she had behavioral problems of taking food from peers during meal times, wandering into others' rooms uninvited, eating and drinking foods not intended for him/her, will take items from the medication cart and consume them and will eat hand sanitizer if applied to hands. One of the interventions initiated on 4/8/24 was to complete environmental monitoring every shift for hazards to resident and monitor if ingested. No intervention was added for additional monitoring to prevent ingestion. The surveyor further reviewed the medical record to identify hazards Resident #34 was ingesting and found a note written on 2/12/25 that stated, another resident reported to staff the Resident #34 may have ingested the urine that was in his/her bedside urinal. The note stated staff were educated to look for ways to reduce incidents of unwanted ingestion while in residents' rooms. Next the surveyor reviewed a progress note written on 5/15/2026 by Licensed Practical Nurse (LPN) #28 in Resident #34's medical record. The note documented, During wound rounds at approximately 11:00 AM, the treatment cart was left in the hallway while wound care was being provided to another resident. A bottle of povidone-iodine solution that had been placed on top of the cart was taken by another resident [Resident #34]. The resident was observed opening the bottle and attempting to drink the solution. The bottle was immediately retrieved from the resident, and no ingestion of the povidone-iodine solution occurred. The resident was redirected without incident. No adjustments to monitoring were noted. On Review of the May Treatment Administration Record (TAR) Resident #34 had no behavior checked. The surveyor reviewed a progress note written on 5/30/26 by LPN #29 that documented Resident #34 was observed wandering in an unsecured area (Baltimore unit, the upstairs unit) at approximately 5:45 PM during dinner time. It was discovered that the resident had removed the wandering device. The resident was safely redirected to the common area, and a new wandering device was applied to his/her right ankle. Staff will continue to closely monitor the resident for safety and well-being. On Review of the May TAR again no behavior had been checked. While on the initial tour of the Baltimore unit on 6/15/26 at about 7 AM- two medication carts and one treatment cart were observed unlocked and unattended on the Baltimore unit.On 6/15/26 at approximately 8:40 AM and again at 11:17 AM, the surveyor observed Resident #34 alone in the room resting in bed with the covers pulled over his/her head. The door was closed on both observations. While making an observation on the Eastern Shore Unit in a common area next to the nurses' station, on 6/16/26 at 8:15 AM, Resident #34 walked up to and swung his/her arm, hitting the surveyor's computer, causing the work screen to close down, and then walked away. On 6/17/26 at 10:15 AM, the surveyor conducted an interview with the Director of Nursing (DON). The surveyor reviewed the concerns regarding Resident #34's level of supervision. The DON stated that Resident # 34 was stopped before ingestion and that she was not even sure if Resident #34 removed his/her own wander guard monitor. However, Resident #34 was assessed as needing close monitoring but continued to experience multiple falls and demonstrated an unstable gait requiring ambulation support. The resident also sustained an injury of unknown origin, attempted to drink from a treatment cart, had known wandering behavior, and successfully left a locked unit without detection. On 6/17/26 at 2 PM, Immediate Jeopardy was determined to exist related to failure to provide adequate supervision to a resident with known safety risks, such as an injury of unknown origin, multiple falls, near-miss ingestion of non-food items, and elopement, which was cited under F689. The immediacy removal plan was accepted on 6/17/26 at 4:16 PM after the initial plan was submitted at 3:46 PM. The plan included placing Resident #34 on a 1:1 supervision, identifying any additional residents with the same need, and educating staff that residents with a 1:1 need to have that intervention in their care plan. Further random observation rounds would be completed to validate (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that 1:1 interventions were provided for appropriate residents weekly x4 then monthly for three months.The removal plan was verified on 6/18/26 at 11am and immediately was abated as of 6/17/26. After the immediacy was removed, the noncompliance was determined to continue with a scope and severity of D.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record reviews, and staff interviews, it was determined that the facility failed to administer medications according to procedures that ensure accurate dispensing and ensure medications were administered to a resident as ordered. This was evident for 1 (Resident #31) out 4 residents observed for medication administration and 1 (Resident #68) out of 2 complaints related to medication administration. The findings include: 1) On 6/18/26 at 7:34 AM, the surveyor observed RN #5 prepare medications for Resident #31. RN #5 asked Resident # 31 if he/she was having pain before administering the medications. Resident #31 acknowledged he/she was having pain and RN #5 informed Resident #31 that she would give him/her pain medication. Next RN #5 obtained Resident #31's as needed tramadol(pain medication) from the locked controlled substance box and signed the medication out on the controlled log book. RN #5 added the medication to Resident #31's morning medication and administered them to the resident. On 6/18/26 at 9:37 AM, the surveyor conducted a medication reconciliation to Resident #31's medication orders. The surveyor reviewed what was scheduled to be given, signed out as given, to what was observed given. On review of the tramadol order, no medication was signed off on Resident #31's Medication Administration Record (MAR) even though it was observed given. On 6/18/26 at 10:24 AM, the surveyor conducted an interview with RN #5. During the interview the surveyor reviewed that the MAR did not show that the tramadol was given. RN #5 stated that it was omitted in error and that she must have not hit save on the administration charting. RN #5 confirmed that it is the expectation to sign out controlled substances in the controlled log book as well as the resident's MAR. 2)On 6/22/26 at 7:19 AM, the surveyor reviewed complaint #2728155. The complaint alleged that Resident #68 missed two doses of his/her antibiotic during his/her stay at the facility. Next the surveyor reviewed Resident #68's Medication Administration Records (MAR). Resident #68 had an order for an antibiotic to be given every 4 hours scheduled at 2AM, 6AM, 10AM, 2PM, 6PM and 10PM. On the January MAR on 1/23/26 the 2AM dose was coded 5- Hold/See progress notes. On review of the progress note written by Registered Nurse (RN) #30 on 1/23/26 it stated, medication not available. On review of the February MAR on 2/9/26 the 6AM, dose was coded 9-Other/See Progress notes. On review of the progress note written by Registered Nurse (RN) #31 on 2/9/26 it stated; Medication not available. On-coming nursing and supervisor made aware. On 6/22/26 at 9:42 AM, the surveyor conducted an interview with the Director of Nursing (DON). The surveyor reviewed the missed doses of Resident #68's antibiotic. The DON confirmed the expectation was to have the medication available and administer medications as they are ordered.