STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215268	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Airy Nursing and Rehab Center	4101 Baltimore National Pike Mount Airy, MD 21771

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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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record reviews and interviews, it was determined that the facility failed to ensure that residents remained free from sexual, physical, and verbal abuse, as well as intimidation by facility staff. This was evident for 3 (Residents #4, #1, and #5) of 4 residents reviewed for allegations of abuse related to facility reported incidents (FRIs #2987931, #2789533, and #3012852).The findings include:1). On 5/21/26 at 1:40 PM, the surveyor conducted a review of the facility-reported incident (FRI #2987931), which indicated that on 4/17/26, Resident #4 reported to Nurse #21 that another resident, Resident #6, had touched [them] in [their] private areas. On 5/21/26 at approximately 2:00 PM, the surveyor reviewed Resident #6's medical records, which revealed a documented pattern of sexually inappropriate, aggressive, and disruptive behaviors toward residents and staff. On 1/8/26, behavioral documentation indicated Resident #6 threatened another resident in the hallway and required staff intervention and redirection. On 1/9/26, Care Plan documentation revealed Resident #6 reportedly told another resident to shut up while in the hallway. Staff redirected the resident and referred them for psychiatric consultation due to ongoing behaviors. On 1/24/26, nursing documentation revealed Resident #6 engaged in a verbal altercation with their roommate that required staff intervention and separation of the residents for safety. On 2/10/26, Care Plan, Social Services, and psychiatric documentation revealed staff and witnesses observed Resident #6 inappropriately touching another resident in the hallway. Witness statements indicated Resident #6 had their hand inside the resident's shirt and removed it when approached by staff. Resident #6 denied the allegation and stated they were patting [them] on the shoulder. Psychiatric follow-up documentation revealed the resident was evaluated for report of inappropriately touching another resident. The psychiatric provider educated Resident #6 that non-consensual sexual contact is considered abuse and documented plans to continue monitoring the resident for inappropriate behaviors. Resident #6 was subsequently placed on 1:1 supervision due to the incident. On 2/11/26 at approximately 11:30 AM, nursing documentation revealed Resident #6 again attempted to touch another resident seated in the hallway. Staff redirected the resident and instructed them that touching another resident without consent was inappropriate. On 2/12/26, nursing documentation confirmed Resident #6 remained on 1:1 supervision due to recent inappropriate touching behaviors. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/4/26, documentation revealed Resident #6 was transferred to the emergency room for psychological evaluation related to aggressive behavior, inability to manage behaviors within the facility, and threats toward other residents. On 3/5/26, post-hospital documentation revealed Resident #6 exhibited aggressive behaviors toward their roommate, used foul language, and attempted to strike the roommate with their walker. Documentation indicated staff redirected the resident multiple times without success prior to hospital transfer. On 3/10/26, behavioral monitoring documentation revealed Resident #6 remained on 1:1 supervision due to ongoing behavioral issues. On 3/18/26, nursing staff documented that while administering medications, Resident #6 attempted to touch the staff member's leg. Staff moved away quickly and instructed the resident that the behavior was not tolerated. On 4/17/26, Care Plan documentation revealed Doctor #24 discontinued Resident #6's 1:1 supervision, documenting the resident has not had any recent behaviors, despite ongoing documented sexually inappropriate and aggressive behaviors. Subsequent documentation revealed ongoing inappropriate behaviors after the discontinuation of the supervision intervention. On 4/17/26, Social Services documentation revealed Resident #6 stated, I did not touch anyone inappropriately, I only touched [their] knee, in response to allegations that Resident #4 had been touched in the private area. On 4/23/26, behavioral documentation noted additional verbal altercations with other residents. On 5/12/26, interdisciplinary documentation revealed Resident #6 remained under review due to physical behaviors toward another resident and a documented history of aggressive behaviors and being inappropriate with [sex removed] residents. Documentation further revealed the resident was routinely followed by psychiatric services with no improvement in behaviors. The interdisciplinary team discussed transfer to an all-[sex removed] facility due to the resident's ongoing inappropriate behaviors toward [sex removed] residents. Documentation further revealed multiple transfer attempts to alternative facilities had been unsuccessful. Review of the FRI follow-up investigation submitted to the Office of Health Care Quality (OHCQ) on 4/23/26 indicated the facility determined the allegation of sexual abuse to be inconclusive despite Resident #6's documented history of sexually inappropriate behaviors toward other residents and staff. On 5/21/26 at 3:26 PM, the surveyor interviewed Geriatric Nursing Assistant (GNA #6), who stated she was aware of Resident #6's sexually inappropriate behaviors toward residents and staff and confirmed there had been prior allegations involving inappropriate sexual behaviors toward other residents before the incident involving Resident #4. GNA #6 stated she was surprised the 1:1 supervision had been discontinued because Resident #6 had ongoing behavioral issues involving other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/26 at 3:45 PM, the surveyor interviewed Resident #4, who stated a [sex removed] had touched their private parts. Resident #4 stated Resident #6 was sitting on the seat of their walker, reached over, and touched their private parts. Resident #4 further stated they had heard Resident #6 had previously done this to another resident. On 5/22/26 at 11:44 AM, the surveyor interviewed the Nursing Home Administrator (NHA), who stated the facility was aware prior to admission that Resident #6 had a history of sexually inappropriate behaviors toward staff. The NHA stated the facility's previous President requested admission of Resident #6 due to low census concerns despite awareness of the resident's behavioral history. The NHA further stated the referral had been facilitated through the President's daughter, who worked as a Social Worker. When asked whether a background review or behavioral screening had been conducted prior to admission to assess potential safety risks to other residents, the NHA stated she was unsure and could not provide documentation indicating such a review had been completed under the prior ownership. The NHA stated the facility had experienced ongoing difficulties managing Resident #6's behaviors since admission and confirmed the resident had been placed on and removed from 1:1 supervision multiple times. The NHA further acknowledged the facility was aware of at least two incidents involving inappropriate touching of other residents, including an incident in which Resident #6 placed their hand down another resident's shirt and groped their breast. The NHA also confirmed Resident #6 had demonstrated aggressive behaviors toward other residents, including physically striking another resident. When asked about discontinuation of the 1:1 supervision, the NHA stated Doctor #22 believed Resident #6 was doing better despite ongoing documented behaviors. The NHA further stated that 1:1 supervision was expensive. The NHA acknowledged the allegation involving Resident #4 occurred the day after the 1:1 supervision was discontinued. The NHA expressed understanding that Resident #6 posed a risk to other residents when not under 1:1 supervision and acknowledged it was likely Resident #4 had been sexually touched by Resident #6. 2). On 5/21/26 at 4:45 PM, the surveyor reviewed Resident #1's Facility Reported Incident (FRI #2789533). The investigation documented that on 2/26/26, Geriatric Nursing Assistant (GNA #18) reported concerns to a supervisor after overhearing a conversation between another GNA (#7) and Licensed Practical Nurse (LPN #19). According to the report, GNA #7 allegedly stated that while she was in training, she was taught to hit Resident #1 and witnessed another aide hit the resident. Further review of the investigation file revealed the following written statement from GNA #18: I am writing to report an incident that was brought to my attention. While I was at the nurse's station with GNA #7 and Nurse #19, I overheard GNA #7 say that one of the aides who trained her in building A hit the resident. In her words, [sex removed]said the aide 'banged [sex removed], yeah she hit [sex removed].' I asked why someone would do that and after that GNA #7 continued speaking with Nurse #19 while I stepped away to tend to another resident. Statements obtained from GNA #7, and LPN #19 denied that the incident occurred. In her written statement, GNA #7 identified the staff member who trained her as GNA #20. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the FRI investigation file revealed a statement dated 2/13/26, prior to the reported allegation, from GNA #20 in which she documented that Resident #1 punched her in the side of the face. There was no additional statement obtained from GNA #20 on or after 2/26/26 related to the abuse allegation. Additionally, there was no evidence that additional staff statements were obtained or that the allegation was comprehensively investigated as abuse. Additionally the FRI investigation failed to show evidence that the facility protected Resident #1 by suspending the staff alleged to be involved in the abuse allegation (GNA #7 and GNA #20) pending the investigation. The Follow-up Investigation Report submitted to the Office of Health Care Quality (OHCQ) on 3/4/26 by the facility Director of Nursing (DON) documented the following: Steps taken to investigate the allegation: Authorities notified, head-to-toe assessment (including pain assessment) conducted, Resident #1 referred to psychiatric services, staff interviewed, and emotional support provided. Summary of interview with witnesses: None Summary of interview with alleged perpetrator(s): None Summary of interview(s) with staff responsible for oversight and supervision of this location: Incident not witnessed Summary of interview(s) with staff responsible for oversight and supervision of alleged perpetrator: None Conclusion: Incident unsubstantiated On 5/22/26 at approximately 10:00 AM, the surveyor reviewed the facility policy and procedure titled Maryland Abuse, Neglect, & Misappropriation (Policy #NS 1300-03). The policy stated, An employee who is alleged or accused of being a party to abuse, neglect, or misappropriation, will be immediately removed from the area(s) of resident care, interviewed by facility leadership for a written statement and not left alone. If multiple employees are involved the employees will not be permitted to be alone in the facility at any time until the investigation is complete. The policy further stated, After completing the statement(s) the employee(s) will be asked to vacate the facility until further investigation of the incident is completed. On 5/22/26 at 10:59 AM, the surveyor conducted an interview with the DON and the Nursing Home Administrator (NHA) regarding the facility's process for handling allegations of abuse. The DON stated that if an allegation involves a staff member, the staff member would be suspended during the investigation and terminated if the allegation is substantiated. She further stated that the facility would obtain statements from staff and assess or interview the resident depending on the residents' cognition level. The surveyor asked whether statements would only be obtained from the staff directly involved in the allegation. The DON stated that statements would be obtained from all staff who provided care to the resident and staff would be asked whether they were aware of any reports or had witnessed abusive behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor then asked, If you had an allegation that a GNA was being abusive toward residents, what would you do as a plan of action to determine if there is validity? The DON responded, The main issue is abuse. The staff members involved in the allegation would be abuse. Due to the unclear response, the surveyor asked specifically about Resident #1 and the allegation that a GNA had been instructed to abuse the resident. The DON stated that GNA #18, who reported the allegation, heard GNA #7 say that she herself hit Resident #1 as instructed by her preceptor, GNA #20. The DON reiterated that the facility would obtain statements from staff and assess or interview the resident depending on the resident's Brief Interview for Mental Status (BIMS), a tool used to assess cognitive status. The surveyor then asked why the staff involved were not suspended and why additional investigative measures were not conducted related to the reported allegation. The DON paused for an extended period and did not initially respond. When prompted again by the surveyor, the DON stated that she asked GNA #7 and LPN #19 about the allegation and, because both denied it, she determined that the allegation was not true. The surveyor then asked how determinations regarding validity of abuse allegations are made. The NHA stated that she reviews investigations with the DON. The surveyor expressed concerns that Resident #1 was not protected from potential abuse, that the allegation was not thoroughly investigated, and that the facility failed to follow its own policy and procedure regarding allegations of abuse and the removal of accused staff from resident care pending completion of the investigation. Both the NHA and DON acknowledged the surveyor's concerns and stated they understood the findings. 3). Resident #5 had diagnoses including, but not limited to, congestive heart failure, type 2 diabetes mellitus, chronic kidney disease, generalized anxiety disorder, moderate intellectual disability, and peripheral vascular disease. The facility identified Resident #5 as having a Brief Interview for Mental Status score of 11. On 5/21/26 at 11:15 AM, a review of the facility-reported incident (FRI #3012852) documentation revealed that on 5/11/26, during the 11:00 PM to 7:00 AM shift, Resident #5 reported that Staff #7, a Geriatric Nursing Assistant (GNA), stated they would break their fingers if Resident #5 did not take medication. On 5/21/26 at 11:20 AM, the review of the facility's investigation summary revealed that Resident #5 reported to the Nursing Home Administrator (NHA) that the night shift nurse had brought medications into the room, but Resident #5 was tired and wanted to take them later. Resident #5 reported that Staff #7 told the resident that if they did not take the medications, Staff #7 would break my fingers. The facility documented that Resident #5 was offered emotional support and referred to psychiatric services. The facility further documented that Staff #7 was suspended during the investigation and later terminated. On 5/21/26 at 11:25 AM, the review of facility staff statements obtained during the facility's investigation revealed that multiple staff members described Staff #7's conduct as loud, rude, disrespectful, aggressive, and inappropriate toward residents and staff. Staff #8, Licensed Practical Nurse (LPN), stated Staff #7 can be loud and rude with staff and residents and was disrespectful to both residents and staff. Staff #9, a GNA, stated Staff #7 needed to be more patient with residents (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and learn to talk to them nicely. Staff #10, an LPN, stated Staff #7 tends to be loud with residents and staff. Staff #11, a GNA, stated Staff #7 was very aggressive when she talks to the residents and that Staff #11 was not comfortable working with Staff #7. Staff #11 also reported overhearing Staff #7 state to the nurse, I told you, that's how you handle them, after an incident involving Resident #5's medication refusal. On 5/21/26 at 2:53 PM, during an interview with Resident #5 in the Building A Day Room, with no other residents or staff present, Resident #5 confirmed the incident occurred. Resident #5 stated they did not want to take the medications while the nurse was administering them. Resident #5 stated that Staff #7 entered the room and said, I'll break your fingers. Resident #5 stated that it was when they took the medication cup from the nurse. On 5/21/26 at 2:55 PM, during the same interview, Resident #5 stated Staff #7 had spoken to them in this manner many times before. Resident #5 provided examples of previous statements by Staff #7, including that Staff #7 told Resident #5 they would contact a psych facility and have me thrown out of here if I don't do what she tells me. Resident #5 further stated that Staff #7 did not strike them but rather grabbed the resident's hand used to take the medication cup. Resident #5 stated Staff #7 made a fist and drew it towards my face. On 5/21/26 at 3:01 PM, Resident #5 continued the interview and stated they had provided a statement to the unit manager and facility social worker. Resident #5 stated they felt safe at the facility overall; however, Resident #5 stated they did not feel safe when cared for by Staff #7 and described feeling scared. Resident #5's description of the incident was consistent with the facility's incident report and investigation documentation. On 5/22/26, at 9:30 AM, a review of the facility's follow-up investigation report revealed that the facility substantiated the allegation based on statements obtained during the investigation process. The facility documented that staff who worked with Staff #7 during the 72 hours prior to the incident reported Staff #7 was loud and disrespectful toward residents and staff. During the review of the facility's follow-up investigation, it was revealed that Staff #7 was terminated from employment at the facility. The facility's corrective action plan identified ongoing abuse reporting education as oversight of implementation of corrective action. On 5/22/26 at 10:59 AM, during an interview with the Director of Nursing (DON), the DON that the facility substantiated that Staff #7 had been disrespectful, rude, and inappropriately interacted with residents and staff. The DON stated the substantiation was corroborated by staff statements regarding Staff #7's conduct toward residents and other staff. When asked whether the finding was considered abuse under facility policy, the DON stated yes. The facility failed to ensure Resident #5 remained free from verbal, mental, and physical intimidation by Staff #7 when Staff #7 threatened to break Resident #5's fingers, grabbed Resident #5's hand, made a fist, and moved the fist toward Resident #5's face during a medication refusal. This failure resulted in Resident #5 reporting fear of Staff #7 and stating they did not feel safe when cared for by Staff #7. Cross-reference F610

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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. Based on record review and interviews, it was determined that the facility failed to ensure timely reporting of an injury of unknown origin in accordance with facility policy and federal requirements. This was evident for 1 of 2 residents (Resident #1) reviewed for a facility reported incident (FRI #2670676) related to an injury of unknown origin.The findings include:According to the facility policy titled Maryland Abuse, Neglect, and Misappropriation (Policy #NS-1300-03), an injury of unknown origin is defined as an injury that was not observed by another person, could not be explained by the resident, and is suspicious due to the location and extent of the injury. Subpart IV, Identification of Incidents and Allegations, stated, The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility. The policy further stated that injuries of unknown origin are to be identified and reported to the supervisor, and that the supervisor or designee will immediately notify the Director of Nursing (DON) and Executive Director/Nursing Home Administrator (NHA) of the incident or allegation.On 5/21/26 at approximately 1:00 PM, the surveyor reviewed the facility's internal investigation related to FRI #2670676 and noted the following:On 11/17/25, Geriatric Nursing Assistant (GNA #12) documented in a written statement that on 11/16/25 they observed a new bruise to Resident #1's eye. GNA #12 stated that another GNA verified the injury and that the nurse supervisor was notified.On 11/17/25, GNA #14 documented in a written statement that on the evening of 11/16/25 they observed bruising to Resident #1's left eyelid and reported it to the supervisor.On 11/17/25, GNA #15 documented that during the night shift on 11/16/25 they observed redness on and around Resident #1's left eye.On 11/17/25, Registered Nurse (RN #16) documented in a written statement, Nothing was reported to me regarding left eye discoloration.On 11/17/25, RN #17 documented that at approximately 6:00 AM she entered Resident #1's room to administer medications and observed bluish discoloration to the resident's left upper eyelid. RN #17 stated that the Manager on Call was notified.On 11/17/25, the Unit Manager (RN #13) documented in a written statement that he did not receive any calls from staff over the weekend regarding bruising or discoloration to Resident #1's left upper eyelid.Federal regulations require that injuries of unknown origin are reported immediately, but not later than 24 hours after discovery, when the events do not involve abuse and do not result in serious bodily injury.Review of the initial report submitted to the Office of Health Care Quality (OHCQ) revealed that the facility documented the injury of unknown origin as having been discovered on 11/17/25 at 7:03 AM. However, RN #17 documented discovery of the injury at approximately 6:00 AM on 11/17/25, and multiple staff members reported observing and reporting the injury sometime on 11/16/25.Although staff members stated they reported the injury to the supervisor in accordance with facility policy, the Unit Manager stated he was not informed of the injury until the morning of 11/17/25. There was no documentation identifying when management was initially notified after staff first observed the injury on 11/16/25.On 5/22/26 at 1:12 PM, the surveyor interviewed the Nursing Home Administrator (NHA) regarding concerns that staff identified the injury on 11/16/25, but facility management was not made aware until the morning of 11/17/25. The NHA stated that staff are expected to immediately report incidents to the Unit Manager, even when the Unit Manager is not physically present in the facility, and that the Unit Manager is then responsible for notifying the DON or NHA. The NHA confirmed that staff failed to follow facility protocol related to reporting the injury of unknown origin.

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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. Based on record reviews and interviews, it was determined that the facility failed to complete the required follow-through after a substantiated allegation of abuse involving a credentialed Geriatric Nursing Assistant and failed to thoroughly investigate allegations of physical and sexual abuse. This was evident for 3 of 4 residents (Resident #5, Resident #1, and Resident #4) reviewed for allegations of abuse related to facility reported incidents (FRI #2789533, #2987931, and #3012852).The findings include: 1). Resident #5 was admitted to the facility with diagnoses including, but not limited to, congestive heart failure, type 2 diabetes mellitus, chronic kidney disease, generalized anxiety disorder, moderate intellectual disability, and peripheral vascular disease. The facility's reported incident summary (FRI #3012852) identified Resident #5 as having a Brief Interview for Mental Status score of 11. On 5/21/26 at 11:20 AM, a review of the facility-reported incident (#3012852) revealed that on 05/11/2026, during the 11:00 PM to 7:00 AM shift, Resident #5 reported that Staff #7, a Geriatric Nursing Assistant (GNA), told Resident #5 they would break their fingers if Resident #5 did not take their medication. The facility documented that the Nursing Home Administrator (NHA), Director of Nursing (DON), Unit Manager, responsible party, and police were notified; Staff #7 was suspended during the investigation; staff statements were obtained; Resident #5 was seen by the psychiatric provider; and Staff #7 was terminated. On 5/21/26 at 2:53 PM, during an interview with Resident #5 in the Building A day room, Resident #5 stated they did not want to take their medications while the nurse was administering them. Resident #5 stated that Staff #7 entered the room and stated, I'll break your fingers, and Resident #5 explained that this was when they took the cup of medication from the nurse. Resident #5 further stated Staff #7 had spoken to them in that manner many times before. Resident #5 also stated Staff #7 previously threatened to contact a psych facility and have Resident #5 thrown out of here. Resident #5 stated Staff #7 did not strike them during the 05/11/2026 incident, but grabbed the hand Resident #5 used to take the medication cup, made a fist, and drew it towards my face. On 5/21/26 at 3:01 PM, Resident #5 stated they had provided a statement to the Unit Manager and to the facility's Social Worker. Resident #5 stated they felt safe at the facility, but did not feel safe when cared for by Staff #7 and described feeling scared. Resident #5's recall of the event was consistent with the facility's incident report. On 5/22/26 at 9:30 AM, a review of the facility's follow-up investigation report revealed that the facility substantiated the allegation based on statements obtained during the investigation. The facility documented that Staff #7 was terminated following a suspension during the investigation, and that statements obtained from staff who worked with Staff #7 during the 72 hours prior to the incident revealed that Staff #7 was loud and disrespectful toward residents and staff. The facility's corrective action plan identified ongoing abuse reporting education as oversight of implementation of corrective action. Review of staff statements contained in the facility's investigation file revealed the following: Staff #8, a Licensed Practical Nurse, documented that Staff #7 can be loud and rude with staff and residents, does not like being told when something is incorrect or wrong, and is disrespectful to both residents and staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff #9, a GNA, documented that Staff #7 needs to be more patient with residents and learn to talk to them nicely. Staff #10, an LPN, documented that Staff #7 tends to be loud with residents and staff. Staff #11 documented that Staff #7 was very aggressive when she talks to the residents, and that Staff #11 was not comfortable working with her. Staff #11 also documented overhearing Staff #7 state to the nurse, I told you, that's how you handle them, after later learning Resident #5 had refused medication. On 5/22/26 at 10:59 AM, during an interview, the DON stated that when an allegation is reported directly by a resident, the facility obtains a statement from the resident, obtains a statement from the staff member who received the report, and interviews the staff member alleged to be involved. The Director of Nursing stated the facility's expectation is for staff to report findings immediately to the NHA and/or DON. The DON stated a GNA may report to the charge nurse, who then reports to the NHA and/or DON. The DON stated the facility understood the Office of Health Care Quality (OHCQ) reporting timeline to be a 2-hour initial report and a 5-day final report. During the same interview, the DON stated that the substantiated finding was that Staff #7 was disrespectful, rude, and inappropriately interacted with residents and staff. The DON stated the substantiation was corroborated by staff statements regarding Staff #7's conduct toward residents and other staff, and confirmed the substantiated finding was considered abuse under the facility's policy. On 5/22/26 at 11:05 AM, during an interview, when asked whether CNA/GNA registry reporting had been initiated, the DON did not respond. The NHA intervened, stating it had not been reported because it's so fresh, and that they had not had an opportunity to report the incident to the nurse aide registry. 8 days had elapsed since the date of Staff #7's termination from the facility and the surveyor's investigation of the incident. When asked why it was not reported, the DON stated that she was unaware of the Maryland Nurse Aide Registry and the process for reporting allegations of abuse involving credentialed persons. On 5/22/26 at 11:05 AM, during the same interview, the NHA confirmed the failure to report the substantiated abuse finding to the nurse aide registry was a systemic/operational oversight and failure. The facility leadership stated that legal/corporate had not been consulted, and confirmed there had been no consideration of mandatory reporting obligations. The NHA and DON confirmed OHCQ had been informed that the allegation was substantiated; however, the substantiated finding had not been reported to the Maryland Nurse Aide Registry. Specifically, the facility substantiated an allegation that Staff #7, a GNA, who threatened Resident #5 during medication administration, terminated Staff #7 following the investigation, and reported the substantiated allegation to OHCQ however, the facility failed to initiate reporting to the Maryland Nurse Aide Registry, failed to consider mandatory reporting obligations related to a credentialed nursing assistant, and failed to ensure facility leadership knew the process for reporting substantiated abuse findings involving a GNA. This failure created the potential for Staff #7 to continue working with vulnerable residents in other settings without the substantiated abuse finding being reported to the appropriate registry for review. 2). On 5/21/26 at 4:45 PM, the surveyor reviewed Resident #1's facility reported incident (FRI (continued on next page)

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	215268	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Airy Nursing and Rehab Center	4101 Baltimore National Pike Mount Airy, MD 21771

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#2789533). The investigation documented that Geriatric Nursing Assistant (GNA #18) reported concerns to a supervisor after overhearing a conversation between another GNA (#7) and Nurse #19. According to the report, GNA #7 allegedly stated that while she was in training, she was taught to hit Resident #1 and witnessed another aide hit the resident. Further review of the investigation file revealed the following written statement from GNA #18: I am writing to report an incident that was brought to my attention. While I was at the nurses station with GNA #7 and Nurse #19, I overheard GNA #7 say that one of the aides who trained her in A building hit the resident. In her words, she said the aide 'banged her, yeah she hit her.' I asked why would someone do that and after that GNA #7 continued speaking with Nurse #19 while I stepped away to tend to another resident. Statements obtained from GNA #7 and Nurse #19 denied that the incident occurred. In her written statement, GNA #7 identified the staff member who trained her as GNA #20. Further review of the facility investigation failed to show evidence that additional staff interviews were conducted, including an interview with GNA #20, the staff member identified as having trained GNA #7 and allegedly hit Resident #1. Additionally, several resident assessment forms were included in the investigation packet; however, six of the assessments were left completely blank and signed by Nurse #21. On 5/22/26 at 10:59 AM, the surveyor interviewed the Director of Nursing (DON) and Nursing Home Administrator (NHA) regarding the facility's investigation process for allegations of abuse. The DON stated that investigations typically begin with staff interviews, resident interviews, and resident assessments. When asked whether she reviews all information collected before determining the investigative outcome, the DON stated that she does. When asked what information a blank assessment provides, the DON stated that it doesn't provide any information. The DON confirmed that Nurse #21 left several assessment forms blank and stated that she must have missed it during review of the investigation. The surveyor then asked specifically why additional staff interviews were not conducted for FRI #2789533. The DON hesitated and shook her head before responding. The surveyor expressed concern that resident assessments were incomplete and that additional staff were not interviewed to determine the validity of the allegation. The DON stated that she asked GNA #7 and Nurse #19 whether they discussed the alleged abuse, and because both denied that it occurred, she determined the allegation to be unsubstantiated without conducting further investigation. 3). On 5/21/26 at 1:40 PM, the surveyor conducted a review of the facility-reported incident (FRI #2987931), which indicated that on 4/17/26, Resident #4 reported to Nurse #21 that another resident, Resident #6, had touched her in her private areas. Further review of the FRI revealed that, as part of the investigation, other residents were interviewed and assessed to determine whether there had been any witnesses or whether other residents had similar experiences. Review of the investigation documentation revealed that nine resident assessment forms completed by the Director of Nursing (DON) on 4/18/26 had been left blank. One assessment form completed by Nurse #21 had also been left blank. On 5/22/26 at 10:59 AM, the surveyor interviewed the DON and Nursing Home Administrator (NHA) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarding the facility's investigation process for allegations of abuse. The DON stated that investigations typically begin with staff interviews, resident interviews, and resident assessments. When asked whether she reviews all information collected before determining the investigative outcome, the DON stated that she does. When asked what information a blank assessment provides, the DON stated that it doesn't provide any information. The DON confirmed that she and Nurse #21 left several assessment forms blank and stated that she must have missed it during review of the investigation. The DON acknowledged that by failing to complete the assessments, important evidence may have been missed during the investigation. The NHA stated that she should have identified the incomplete assessments as well, as she and the DON review investigative findings together before determining the outcome of the investigation. Cross-reference F600

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record reviews and interviews, it was determined that the facility failed to include adverse event monitoring of alleged physical and sexual abuse in the facility's Quality Assurance and Performance Improvement (QAPI) activities. This was evident for 2 of 2 facility reported incidents (FRI #2670676 and #2686939) involving injuries of unknown origin and 4 of 4 facility reported incidents (FRI #2707002, #2787931, #2987931, and #3012852) involving allegations of abuse.The findings include:Definitions:Abuse is the willful infliction of injury, intimidation, or punishment resulting in physical harm, pain, or mental anguish.Sexual abuse is non-consensual sexual contact of any type.An injury of unknown origin is an injury that was not observed by another person, cannot be explained by the resident, and is suspicious because of the extent of the injury or the location of the injury.A QAPI (Quality Assurance and Performance Improvement) committee is a group within a healthcare facility responsible for continuously evaluating and improving resident care, safety, and operational performance through data-driven analysis and performance improvement activities.According to the facility policy and procedure (Policy #NS 1300-03), Maryland Abuse, Neglect, and Misappropriation, all investigations involving abuse, neglect, and misappropriation will be reviewed by the QAPI committee.On 5/21/26, throughout the first day of the change of ownership and facility reported incident (FRI) investigation survey, the surveyors reviewed six FRIs alleging the following:-FRI #2670676 - Injury of unknown origin-FRI #2686939 - Injury of unknown origin-FRI #2707002 - Alleged employee-to-resident abuse-FRI #2787931 - Alleged employee-to-resident abuse-FRI #2987931 - Alleged resident-to-resident sexual abuse-FRI #3012852 - Alleged employee-to-resident abuseOn 5/22/26 at 2:37 PM, the surveyor conducted an interview with the Nursing Home Administrator regarding how the QAPI committee determines areas requiring performance improvement activities and monitoring. The Nursing Home Administrator stated that resident safety is prioritized when determining areas of focus. When asked whether any of the alleged abuse incidents or injuries of unknown origin had been reviewed or tracked through the facility's QAPI process, she stated that they had not.Cross-reference F600, F609, & F610