STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, and interview, the facility failed to ensure staff communicated all pertinent information to a physician, which affected 1 (Resident #4) of 4 residents reviewed for abuse. Findings included:A facility policy titled, Change in a Resident's Condition or Status, dated 02/2021, indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g. [exempli gratia; for example], changes in level of care, billing/payments, resident rights, etc. [et cetera; and so forth]. The policy revealed, 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an), which included, a. accident or incident involving the resident, d. significant change in the resident's physical/emotional/mental condition, and g. need to transfer the resident to a hospital center. The policy also indicated, 3. Prior to notifying the physician or healthcare provider, the nurse will make detained observation and gather relevant and pertinent information for the provider, including (for example) information prompted by the interact SBAR [Situation, Background, Assessment, Recommendation] Communication Form.A facility policy titled, Acute Condition Changes-Clinical Protocol, dated 03/2018, indicated, 7. Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician; for example, the history of present illness and previous and recent test results for comparison. The policy continued, a. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. The policy also indicated, 8. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). The policy revealed, 9. The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. The policy continued, a. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response.An admission Record revealed the facility admitted Resident #4 on [DATE] and discharged the resident on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing) and aphasia (a communication disorder) following cerebral infarction (a stroke), gastrostomy tube, chronic obstructive pulmonary disease (COPD), paroxysmal atrial fibrillation (occasional irregular heartbeat), atherosclerotic heart disease, and congestive heart failure (CHF).A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident did exhibit behavioral symptoms and required maximal assistance from staff for activities of daily living (ADLs), including personal and oral hygiene, toileting, bathing, dressing, and putting on footwear. The MDS revealed that no falls were recorded for the resident since admission, and the resident did not have a fracture related to a fall in the previous six months.Resident #4's Care Plan Report included a focus area initiated [DATE], that indicated the resident had an altered cardiovascular status related to hypertension, atrial fibrillation, cardiovascular disease, and indicated that the resident had a pacemaker. Interventions initiated [DATE] directed staff to monitor, document, and report as necessary any signs or symptoms of cardiovascular disease including chest pain, nausea and vomiting, shortness of breath, changes in capillary refill, and color/warmth of the resident's extremities.Resident #4's SBAR Change in Condition, dated [DATE] at 2:54 AM and locked at 3:01 AM, revealed that Resident #4 had a fall from bed at 12:15 AM and NP #29 was called at 12:40 AM. The record indicated that NP #29 had not returned the call at that time. Per the record, the nurse completed a change in condition assessment, completed a neurological check, and assessed the resident for any changes. The record revealed the Respiratory Evaluation and Abdominal/GI [Gastrointestinal] Evaluation were marked as Not clinically applicable to the change in condition being reported.Resident #4's Progress Notes revealed a note, dated [DATE] at 4:43 AM and electronically signed by the Director of Nursing (DON), who was the Assistant Director of Nursing (ADON) at the time of the incident, that indicated that she and Licensed Practical Nurse (LPN) #17 assessed the resident. The note indicated the resident appeared slightly gray in color, their pulse varied between 122-131 beats per minute, the resident had a history of atrial fibrillation, and the resident was a mouth breather and oxygen saturation rates were 86% - 91% on room air

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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. (continued on next page)

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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	Based on facility policy review, record review, facility document review, and interview, the facility failed to protect the resident's right to be free from physical and verbal abuse by a staff member for 1 (Resident #4) of 4 residents sampled for abuse during the complaint survey. Findings included:A facility policy titled, Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revised 11/06/2024, revealed, An owner, licensee, administrator, licensed nurse, employee, or volunteer of a nursing home shall not physically, mentally, or emotionally abuse, mistreat, or harmfully neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment neglect, or misappropriation shall immediately report to the Nursing Home Administrator.An admission Record revealed the facility admitted Resident #4 on 12/11/2024. According to the admission Record, the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing) and aphasia (an inability to understand or produce speech) following cerebral infarction (a stroke), gastrostomy tube, chronic obstructive pulmonary disease (COPD), paroxysmal atrial fibrillation, atherosclerotic heart disease, and congestive heart failure.A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident did not exhibit any behavioral symptoms during the assessment timeframe. Per the MDS, the resident required maximal assistance from staff for activities of daily living (ADLs), including personal and oral hygiene, toileting, bathing, dressing, and putting on footwear. The MDS indicated the resident did not have any falls since admission, and the resident did not have a fracture related to a fall in the previous six months. Resident #4's Care Plan Report included a focus area initiated 12/13/2024, that indicated the resident had a self-care deficit related to cerebral infarction. Interventions dated 12/13/2024 directed staff to provide Resident #4 with assistance from two staff for walking and transfers, assist with repositioning, fall precautions, and indicated the resident utilized a wheelchair. A Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Initial Report Form, dated 12/17/2024, revealed the facility reported an incident of physical and mental/verbal abuse involving Resident #4, perpetrated by LPN #3. The document indicated that the incident occurred at 1:02 AM on 12/17/2024. Per the document, two geriatric nursing assistants (GNAs), GNA #2 and GNA #4, witnessed LPN #3 being rude and rough with Resident #4 when assessing the resident for injuries after a fall. The report indicated that the GNAs reported the alleged abuse to LPN #6, who reported it to the Director of Nursing (DON), who was the Assistant Director of Nursing (ADON) at that time, who then reported it to the former DON (in the position at the time of the alleged incident). The report indicated that Resident #4 did not have serious bodily harm or injuries as a result of the alleged abuse.A Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Follow-Up Investigation Report Form, dated 12/23/2024, indicated, 3. Conclusion revealed, After the investigation of the incident the allegation has been verified. The report indicated that multiple staff members reported witnessing LPN #3 being rough, rude, and mean to Resident #4. The report indicated that staff seen and heard LPN #3 yelling and pulling on Resident #4's arm. A written statement signed by LPN #6, dated 12/17/2024, indicated that GNA #2 and GNA #4 reported to her that LPN #3 was rude and rough with Resident #4 during a fall assessment. Per the statement, GNA #2 witnessed LPN #3 pull hard on the resident's arm and yell at the resident to stop. The statement indicated that the resident was not able to move, but LPN #3 kept pulling on the resident really hard on their arm. The statement indicated that GNA #4 reported that LPN #3 pulled a blood pressure cuff off the resident very rough and caused the cuff to break.A written statement signed by GNA #4, dated 12/17/2024, indicated that she, along with LPN #3, GNA #2, and GNA #5, assisted Resident #4 following the resident's fall out of bed. The statement indicated that she witnessed LPN #3 be mean to Resident #4 and yelled at the resident to stop moving. Per the statement, LPN #3 pulled the resident's arm really hard and yelled at the resident. The statement indicated that LPN also spoke to the resident rudely when the resident was on the floor.An undated written statement signed by GNA #2 indicated that on 12/16/2024, LPN #3 was rude and disrespectful to Resident #4. The statement indicated that the resident had fallen out of bed when she was asked to help GNA #5, GNA #4, and LPN #3 pick the resident up. The statement indicated that she witnessed LPN #3 yell at the resident to stop moving so much and witnessed her pushing, pulling, and jerking [Resident #4] around.A written statement signed by GNA #5, dated 12/17/2024, indicated that she witnessed LPN #3 being rough with Resident #4 after the resident fell out of bed. The statement indicated

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to implement their policies regarding investigating, documenting, and reporting an incident of resident-to-resident abuse, for one (Resident #14) of 12 residents reviewed for abuse or resident-to-resident altercations during the complaint survey.Findings included:A facility policy titled, Resident-to-Resident Altercations, revised 09/2022, indicated Policy Statement - All altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the nursing supervisor, the director of nursing services and to the administrator. The policy also indicated, 4. If two residents are involved in an altercation, staff: a. separate the residents, and institute measures to calm the situation; b. identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation; and c. notify each resident's representative and attending physician of the incident. The policy continued, i. complete a Risk Management form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record; and j. report incidents, findings, and corrective measures to appropriate agencies as outlined in Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation.A facility policy titled, Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, dated 11/06/2024, indicated, Reporting - I. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: A. The State licensing/certification agency responsible for surveying/licensing the facility. The policy also indicated, Abuse Investigating and Reporting - I. If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the incident will be reported immediately to one of the following: Administrator, DON [Director of Nursing], or Charge Nurse. II. Supporting documents relative to alleged incident will be obtained. The policy continued, V. The Administrator or his/her designee, will provide the appropriate agencies or individuals listed above with written report of the findings of the investigation withing five (5) working/business days of the initial self-report.An admission Record revealed the facility admitted Resident #13 on 12/22/2023. According to the admission Record, the resident had a medical history that included a diagnosis of cerebral infarction (a stroke).A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/24/2025, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #13 exhibited physical and verbal behaviors directed toward others and other behavioral symptoms not directed toward others one to three days during the seven day assessment look-back period.Resident #13's Care Plan Report included a focus area, revised 12/28/2023, that indicated the resident had a behavior problem related to exit seeking and sitting on the floor. Interventions directed staff to monitor behavior episodes and attempt to determine the underlying cause, initiated 12/27/2023.An admission Record revealed the facility admitted Resident #14 on 06/17/2025. According to the admission Record, the resident had a medical history that included a diagnosis of dementia.A quarterly MDS, with an ARD of 09/24/2025, revealed Resident #14 had a BIMS score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #14 exhibited no physical or verbal behaviors directed toward others during the seven day assessment look-back period.Resident #14's Care Plan Report included a focus area, initiated 07/02/2025, that indicated the resident had inappropriate behaviors related to poor insight and judgement, related to dementia. Interventions directed staff to set limits and make the resident aware that behavior was inappropriate at the time the behavior occurred, initiated 07/02/2025.A Witness Statement by Licensed Practical Nurse (LPN) #9, dated 09/14/2025, indicated that at 11:35 PM Resident #13 was grabbing Resident #14 by the shirt collar, and Registered Nurse (RN) #32 was in between the residents attempting to get the residents away from one another. A Witness Statement by Geriatric Nursing Assistant (GNA) #44, dated 09/14/2025, indicated that at 11:35 PM, she walked over to the secure unit and saw a nurse positioned between two residents to keep them separated. The statement indicated GNA #44 helped another resident away from the situation. A Witness Statement by the Director of Nursing (DON), dated 09/14/2025, indicated that at 11:35 PM there was Resident to Resident incident. The statement indicated Resident #13 was standing behind Resident #14, and Resident #13 was holding and pulling on Resident #14's shirt collar. The statement indicated staff redirected Resident #13 away from Resident #14. A nurse's Progress Note[s], dated 09/15/2025 at 2:18 AM, revealed that on 09/14/2025 at 11:35 PM Resident #13 pushed their

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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 - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on facility policy review, record review, facility document review, and interview, the facility failed to report allegations of abuse, including injury of unknown origin, to the state survey agency within the required timeframe, which affected 6 (Residents #14, #15, #4, #7, #19, and #10) of 12 residents reviewed for abuse or resident-to-resident altercations.Findings included: A facility policy titled, Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revised 11/06/2024, revealed, Reporting included, I. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies, which included, A. The State licensing/certification agency responsible for surveying/licensing the facility. The policy continued, II. An alleged violation is considered by, but not limited to neglect, exploitation, mistreatment, physical abuse, sexual abuse, mental abuse, injuries of an unknown source and misappropriation of resident property, involuntary seclusion or meet the definition of the below descriptions will be reported immediately but not later than, including, A. Two (2) hours (of knowledge of the allegation or injury noted) if the alleged violation resulted in, which included, 1. Serious bodily injury, 2. Harm/injury sustained from an unknown origin, 3. Allegation of abuse, and 4. Resident to resident altercations. 1. An admission Record revealed the facility admitted Resident #9 on 01/31/2023. According to the admission Record, the resident had a medical history that included diagnoses of dementia, major depressive disorder, and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/28/2025, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #9 exhibited no physical or verbal behaviors during the assessment look-back period. Resident #9's Care Plan Report included a focus area revised 07/31/2024, that indicated the resident had inappropriate behaviors at times that included sitting on the floor and packing their clothing and sitting at the nurse station, stating that their family was coming to pick up the resident. Interventions directed staff to refer the resident to behavioral health services as indicated (initiated 10/31/2023). An admission Record revealed the facility admitted Resident #15 on 08/02/2019. According to the admission Record, the resident had a medical history that included a diagnosis of dementia. A quarterly MDS, with an ARD of 07/01/2025, revealed Resident #15 had a BIMS score of 2, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident exhibited no physical or verbal behaviors during the assessment look-back period. Resident #15's Care Plan Report included a focus area initiated 04/28/2024, that indicated the resident had a behavioral problem that involved wandering into other residents' rooms, related to dementia. Interventions directed staff to intervene as necessary to protect the rights and safety of others (initiated 04/28/2024 and revised 10/21/2024). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9's Progress Notes revealed a physician progress note, dated 9/18/2025 at 2:18 PM, that indicated the resident was examined after it was reported that the resident had attempted to dump another resident out of [his/her] wheelchair. Per the note, Resident #9 would not make eye contact or answer any questions but would only say that they wanted to go home. Resident #15's Progress Notes revealed a physician progress note, dated 9/18/2025 at 1:58 PM, that indicated the resident was examined after another resident had attempted to dump [Resident #15] from the wheelchair [the resident] was sitting in. During an interview on 10/11/2025 at approximately 9:00 AM, the Director of Nursing (DON) stated that resident-to-resident altercations were reportable to the state survey agency. Per the DON, the incident between Resident #9 and Resident #15 was discussed but since Resident #9 had not touched Resident #15, they were told that incident was also not reportable. During an interview on 10/11/2025 at 9:22 AM, the Administrator (ADM) stated that resident-to-resident altercations fell under abuse, which was reportable. The ADM stated she was never informed of an altercation between Resident #9 and Resident #15. The ADM stated her expectation was that a resident-to-resident altercation be reported to the SSA. 2. An admission Record revealed the facility admitted Resident #4 on 12/11/2024. According to the admission Record, the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing) and aphasia (an inability to understand or produce speech) following cerebral infarction (a stroke), gastrostomy tube, chronic obstructive pulmonary disease (COPD), paroxysmal atrial fibrillation, atherosclerotic heart disease, and congestive heart failure. A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed that the resident did not exhibit any behavioral symptoms during the assessment timeframe. Per the MDS, the resident required maximal assistance from staff for activities of daily living (ADLs), including personal and oral hygiene, toileting, bathing, dressing, and putting on footwear. The MDS indicated the resident did not have any falls since admission, and the resident did not have a fracture related to a fall in the previous six months. Resident #4's Care Plan Report included a focus area initiated 12/13/2024, that indicated the resident had a self-care deficit related to cerebral infarction. Interventions dated 12/13/2024 directed staff to provide Resident #4 with assistance from two staff for walking and transfers, assist with repositioning, fall precautions, and indicated the resident utilized a wheelchair. A Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Initial Report Form, dated 12/17/2024, revealed the facility reported an incident of physical and mental/verbal abuse involving Resident #4, perpetrated by Licensed Practical Nurse (LPN) #3. The document indicated that the incident occurred at 1:02 AM on 12/17/2024. Per the document, two geriatric nursing assistants (GNAs), GNA #2 and GNA #4, witnessed LPN #3 being rude and rough with Resident #4 when assessing the resident for injuries after a fall. The report indicated that the GNAs reported the alleged abuse to LPN #6, who reported it to the current Director of Nursing (DON), who was the Assistant Director of Nursing (ADON) at that time, who then reported it to the former DON (in the position at the time of the alleged incident). The initial report indicated that it was submitted to the state survey agency on 12/27/25024 at 12:30 PM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An email to the former DON, dated 12/17/2024 at 2:09 PM, revealed confirmation that the state survey agency received the initial report. During an interview on 10/13/2025 at 11:24 AM, the former DON stated the facility tried to follow a two-hour timeline to report an allegation of abuse to the state survey agency. She stated they were required to contact their corporate office when there was an allegation of abuse to walk through the steps to complete the report. She stated that if the report was sent in later than the two-hour timeframe, then it was because the corporate office did not respond to the facility timely. During an interview on 10/13/2025 at 2:55 PM, the Administrator stated that for an abuse allegation, the initial report should be sent to the SSA within two hours, and the final report within five working days. During an interview on 10/15/2025 at 11:17 AM, the Regional Director of Operations (RDO) stated they collaborated with the facility when there was a reportable event and assisted the facility as needed. The RDO stated that the allegation should have been reported initially within two hours as per the regulation. 3. An admission Record indicated the facility admitted Resident #7 on 04/09/2024. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety; polyosteoarthritis; other specified disorders of bone density and structure; and generalized muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/01/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #7 had inattention and disorganized thinking. The MDS indicated Resident #7 had no functional limitations in movement of the upper extremities. According to the MDS, the resident was dependent on staff for bed mobility, moving from a sitting to lying position, and tub/shower transfers. Per the MDS, the resident required substantial/maximal assistance with lying to sitting on the side of the bed, moving from a sitting to a standing position, chair/bed-to-chair transfers, and toilet transfers. The MDS indicated the resident was able to walk 10 feet with partial/moderate assistance. The MDS also revealed that Resident #7's fall history on admission/entry or reentry included a fall in the previous month, a fall in the previous two to six months, and had a fracture related to a fall in the previous six months. Resident #7's Care Plan Report included a focus area initiated 09/19/2024, that indicated the resident had an alteration in their musculoskeletal status related to positive ulnar [the ulna bone is in lower arm and runs from the elbow to the wrist on the little finger side of the arm] variance. Interventions directed staff to make sure the call light was within the resident's reach, respond promptly to requests for assistance, and to educate the resident/family/caregivers on safety measures to reduce the risk of falls (initiated 09/19/2024). Resident #7's Physical Therapy Treatment Encounter Note(s), dated 03/27/2025, indicated that the Assistant Director of Nursing (ADON) checked Resident #7's left distal wrist, and the resident was transported to the first-floor nurses' station for the provider to evaluate the resident's left hand and wrist. (continued on next page)

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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 - Some	Acute visit summary Progress Notes dated 03/27/2025 revealed a physician's assistant (PA) examined Resident #7 because therapy staff noticed the resident's left wrist was swollen and seemed tender. The note indicated Resident #7 fell frequently and due to dementia and indicated that pain and injury were hard to assess. The note also indicated that on assessment, Resident #7 had edema to the left wrist, the wrist was tender, and the resident pulled away from the PA when the distal radius and ulna were palpated. The note indicated that Resident #7 had a history of cellulitis and an old fracture in the same area. Per the note, an X-ray was ordered to determine whether Resident #7 had a fracture or bony abnormalities. Resident #7's Progress Notes revealed a note, dated 03/28/2025 at 12:49 PM, that indicated a mobile X-ray company completed the ordered X-rays. Resident #7's Progress Notes revealed a note, dated 03/28/2025 at 10:54 PM, that revealed the results of the X-rays were returned to the facility, indicating the resident had an acute fracture of the distal ulna. A Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Initial Report Form indicated that the facility reported an injury of unknown source related to Resident #7's acute distal fracture of the distal ulna. The document indicated that the X-ray results were received on 03/28/20254 at 10:45 PM and was reported to the former Director of Nursing (DON). The document was completed by the former DON and indicated that it was submitted to the state survey agency on 03/29/2025 at 11:00 AM. An email to the former DON, dated 03/29/2025 at 12:32 PM, revealed confirmation of the initial report regarding Resident #7's injury of unknown origin, which was approximately 14 hours after the facility received the X-ray report that indicated the resident had an ulna fracture. During a telephone interview on 10/15/2025 at 11:11 AM, the former DON stated that she always followed the two-hour timeline for reporting to the state survey agency. She stated that before submitting a report to the state survey agency, she notified corporate staff and someone from the corporate office walked her through the steps of the report. The Regional Director of Operations (RDO) was interviewed on 10/15/2025 at 11:33 AM. The RDO stated that for any issue that required a report to the state survey agency, the facility was also expected to contact him as soon as possible. The RDO stated that the corporate office staff collaborated with the facility staff to make sure the resident involved was kept as safe as possible. The RDO stated the corporate office was there to lend guidance, but the facility was able to send reports to the state survey agency when they chose. The RDO stated that the reporting timeframe for an injury of unknown origin was two hours. The RDO reviewed the report sent to the state agency for Resident #7 on 03/29/2025 and revealed that the report had been submitted late. The facility's current DON was interviewed on 10/15/2025 at 11:05 AM. The DON stated that the timeframe for reporting an injury of unknown origin was two hours; therefore, the 03/29/2025 report was submitted late. The DON stated that the X-ray of Resident #7's wrist indicated an acute fracture, which meant the fracture was new and had not started healing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator (ADM) was interviewed on 10/15/2025 at 10:51 AM. The ADM stated injuries of unknown origin should be reported to the state survey agency within two hours. The ADM reviewed the initial report related to Resident #7's fracture and stated that if the staff were aware of the fracture on 03/28/2025 and the former DON did not report the injury to the state survey agency until 03/29/2025, then the report was submitted late. The ADM stated that she had just started at the facility in March 2025, and the former DON had not shared with her when the report was submitted to the state survey agency. 4. An admission Record revealed the facility admitted Resident #19 on 11/06/2019. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and the membrane that cover it) affecting the left non-dominant side, recurrent major depressive disorder, difficulty in walking, alcohol-induced disorder, and other abnormalities of gait and mobility. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2025, revealed Resident #19 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated that the resident did not exhibit any physical or verbal behavioral symptoms directed at others. An admission Record revealed the facility admitted Resident #3 on 10/16/2024. According to the admission Record, the resident had a medical history that included diagnoses of early onset Alzheimer's disease, brief psychotic disorder, severe dementia with other behavioral disturbance, depression, generalized muscle weakness, difficulty in walking, and fatigue. An admission MDS, with an ARD of 10/24/2024, revealed Resident #3 had a BIMS of 4, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #3 exhibited physical and verbal behavioral symptoms directed toward others on one to three days during the seven-day look-back period. Per the MDS, the behavioral symptoms did not put others at significant risk for injury. The MDS also revealed that Resident #3 exhibited wandering behaviors on four to six days during the seven-day look-back period. According to the MDS, the wandering behavior did not intrude on the privacy or activities of others. Resident #3's Care Plan Report revealed a focus area initiated 10/18/2024, that indicated the resident had a cognitive decline related to dementia. The Care Plan Report also revealed a focus area initiated 10/18/2024, that indicated the resident was at risk for wandering or pacing. The resident's Care Plan Report also revealed a focus area initiated 11/22/2024, that indicated the resident was often aggressive and agitated with staff. Interventions directed staff to be alert of safety concerns to prevent injury to the resident or others (initiated 12/09/2024). Resident #3's Progress Notes revealed a note, dated 12/13/2024 at 4:10 AM, that revealed that at 7:30 PM, Licensed Practical Nurse (LPN) #37 was notified that Resident #3 was in Resident #19's room, and it appeared that Resident #3 was trying to choke Resident #19. The note indicated that Resident #3 was also observed pushing Resident #19's tray table against Resident #19's leg. Per the note, there were no injuries or bruises to Resident #19's neck or legs. The note revealed staff assisted Resident #3 to the hallway, gave the resident snacks, and administered medications until Resident #3 appeared to be ready to go to bed. The Progress Notes did not indicate whether the Director of Nursing (DON) or the Administrator (ADM) were notified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's record revealed no documented evidence that the facility reported the incident to the state survey agency. During an interview on 10/09/2025 at 2:52 PM, LPN #37 stated that a geriatric nursing assistant (GNA) reported that Resident #3 attempted to choke Resident #19. LPN #37 stated she did not witness the incident; she only documented what the GNA reported. LPN #37 stated they assessed Resident #19, who had no injuries. LPN #37 stated she reported the alleged resident-to-resident abuse to the former DON (in the position at the time of the alleged incident) and to the nurses on the following shift. During an interview on 10/09/2025 at 6:31 PM, the former DON stated she vaguely remembered the allegation involving resident-to-resident abuse between Resident #3 and Resident #19. The former DON stated that she would have notified the ADM of the abuse allegation. She stated that she was unable to recall whether the abuse allegation was reported to the state survey agency. During an interview on 10/13/2025 at 12:21 PM, the facility's current DON stated the alleged resident-to-resident abuse between Resident #3 and Resident #19 should have been reported to the Assistant Director of Nursing (ADON) or the DON (whoever was on-call), the ADM, corporate staff, and to the state survey agency within two hours of the incident. The DON stated the allegation should have been reported timely so they could capture what truly happened, for the safety of the residents. During an interview on 10/15/2025 at 6:22 PM, the ADM stated abuse allegations should be reported within two hours. 5. An admission Record revealed the facility admitted Resident #10 on 12/12/2024. According to the admission Record, the resident had a medical history that included diagnoses of displaced intertrochanteric fracture of right femur and subsequent encounter for closed fracture with routine healing (onset date 6/02/2025); repeated falls; unspecified dementia, generalized muscle weakness, difficulty in walking, fatigue, and ataxic gait. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/05/2025, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. An admission Record revealed the facility admitted Resident #1 on 12/27/2023 and readmitted the resident on 03/04/2024. According to the admission Record, the resident had a medical history that included diagnoses of Wernick's encephalopathy, uncomplicated alcohol use, vitamin B12 deficiency anemia, unspecified dementia, generalized muscle weakness, difficulty in walking, unspecified hallucinations, and fatigue. A quarterly MDS, with an ARD of 06/11/2025, revealed Resident #1 had a BIMS of 0, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #1 displayed no physical or verbal behavioral symptoms during the assessment look-back period. Resident #1's Care Plan Report revealed a focus area initiated 02/28/2025, that indicated the resident had the potential to be aggressive and agitated. According to the Care Plan Report, prior to 05/28/2025, there were two incidents when Resident #1 hit another resident. Interventions directed staff to be alert to prevent injury to the resident or others and to remove potentially harmful items from Resident #1's access (initiated 02/28/2025). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #10's Progress Notes revealed a note, dated 05/28/2025 at 11:14 PM, that indicated Resident #10 was standing in the hallway talking to their roommate (Resident #1), telling Resident #1 that they had been roommates for quite a while. Per the Progress Notes, Resident #1 was upset because they were not able to sleep with another resident, who Resident #1 thought was their spouse. The note revealed that Resident #1 became aggressive and tried to hit Resident #10. The note indicated that Resident #10 stepped backwards to get away from Resident #1 and fell on to their back. The note revealed Resident #1 complained of pain to the lower back, right hip, right knee, and right upper leg. The note also revealed that Resident #1 was unable to bear weight on their right leg and had pain with standing or moving. A Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Initial Report Form indicated the facility reported the incident between Resident #1 and Resident #10 to the state survey agency. The form indicated that Resident #1 tried to hit Resident #10, who then stepped backwards to get away, and fell. The form indicated that the date and time the facility became aware of the incident was on 05/28/2025 at 9:40 PM. The form indicated the date and time the Administrator (ADM) was notified was on 05/29/2025 at 9:00 AM. The form indicated that it was completed by the former Director of Nursing (DON) (in the position at the time of the incident) and submitted the form on 05/29/2025 at 11:45 AM. An email to the former DON, dated 05/29/2025 at 1:21 PM, revealed confirmation that the state survey agency received the initial report. During a telephone interview on 10/09/2025 at 2:32 PM, Geriatric Nursing Assistant (GNA) #13 revealed Resident #1 believed that another resident (Resident #30) was their spouse and was walking towards that resident's room. GNA #13 stated that she closed Resident #30's door and Resident #1 got aggressive and combative towards the GNA. GNA #13 stated that Resident #10 then walked out of their room and tried to coach Resident #1 back to their shared room. She stated that Resident #1 turned, grabbed a trash can lid, and headed towards Resident #10. GNA #13 stated she grabbed the trash can lid from Resident #1; however, by that time, Resident #10 jumped back to get away from Resident #1 and fell backward. GNA #13 stated that Registered Nurse (RN) #32 and GNA #40 came and assisted in separating and taking care of Resident #1 and Resident #10. During an interview on 10/13/2025 at 12:21 PM, the facility's current DON stated the alleged resident-to-resident abuse should have been reported within two hours of the incident to the Assistant Director of Nursing (ADON) or the DON (whoever was on-call), the ADM, the corporate staff, and to the state survey agency. The DON stated the allegation should have been reported timely so they could capture what truly happened, for the safety of the residents. During an interview on 10/15/2025 at 6:22 PM, the ADM stated abuse allegations should be reported within two hours. 6. An admission Record revealed the facility admitted Resident #13 on 12/22/2023. According to the admission Record, the resident had a medical history that included a diagnosis of cerebral infarction (a stroke). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/24/2025, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #13 exhibited physical and verbal behaviors directed toward others, and other behavioral symptoms not directed toward others one to three days during the seven-day assessment look-back period. Resident #13's Care Plan Report included a focus area, revised 12/28/2023, that indicated the resident had a behavior problem related to exit seeking and sitting on the floor. Interventions initiated 12/27/2023 directed staff to monitor behavior episodes and attempt to determine the underlying cause. An admission Record revealed the facility admitted Resident #14 on 06/17/2025. According to the admission Record, the resident had a medical history that included a diagnosis of dementia. A quarterly MDS, with an ARD of 09/24/2025, revealed Resident #14 had a BIMS score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #14 exhibited no physical or verbal behaviors directed toward others during the seven-day assessment look-back period. Resident #14's Care Plan Report included a focus area, initiated 07/02/2025, that indicated the resident had inappropriate behaviors related to poor insight and judgement, related to dementia. Interventions initiated 07/02/2025 directed staff to set limits and make the resident aware that behavior was inappropriate at the time the behavior occurred. Resident #14's Progress Notes revealed a note, dated 9/15/2025 at 2:30 AM, that revealed Resident #14 was brought to the nursing desk in their wheelchair by Resident #13, and indicated that Resident #14 was upset and crying. The note indicated Resident #13 had Resident #14 by their shirt collar, and the nurse had to get additional staff assistance to separate the residents. Resident #14's record revealed no evidence of a resident-to-resident abuse incident involving Resident #13 and Resident #14 being reported to the state survey agency. During an interview on 11/06/2025 at 3:09 PM, the facility's current DON stated that she was in the 100 Hall when she got a call from Registered Nurse (RN) #32, who was on the secured unit, and she stated she needed help. She stated that she and Licensed Practical Nurse (LPN) #9 went to the secured unit and when they arrived, Resident #13 was standing behind Resident #14 and had ahold of Resident #14's shirt collar. She stated that it did not take long to redirect Resident #13 and separate the residents. She stated that she notified the former DON (in the position at the time of the incident), who said she was going to call corporate staff to discuss the resident-to-resident altercation. She stated that the former DON called her back and told her that it did not need to be reported and to tell RN #32 to document it as a behavior. She stated that she believed the incident should have been investigated and reported to the state survey agency and to the police. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/07/2025 at 8:51 AM, RN #32 stated that she was sitting at the desk charting and looked up and saw Resident #13 pushing Resident #14 down the hallway in their (Resident #14's) wheelchair, and Resident #14 was crying. She stated Resident #13 had a hold of Resident #14's shirt collar, pulling it, saying to get the resident out of their room and to call the police. She stated she had to call for help to get them separated, and she kept Resident #13 at the desk in a recliner. She stated that the former DON was called, and she called corporate staff, then called back and said the Regional Director of Operations (RDO) said it was not an altercation. She stated she told the current DON that she did not feel comfortable with that decision and was going to document what she saw. RN #32 stated that the altercation was resident-to-resident abuse. During an interview on 11/07/2025 at 9:50 AM, the Regional Nurse Consultant (RNC) stated she was not called about the incident involving Resident #13 and Resident #14. She stated the facility was supposed to call her and the RDO to discuss the incident, and she did not get a call, and the RDO told her that he did not get a call either. During an interview on 11/07/2025 at 2:23 PM, the RDO stated that he was not notified of the incident between Resident #13 and Resident #14, and that was one of the reasons the former DON's employment was terminated. During an interview on 10/11/2025 at 9:22 AM, the Administrator (ADM) stated that resident-to-resident altercations fell under abuse, which was reportable. Regarding the incident between Resident #13 and Resident #14, the ADM stated that the former DON told her that one resident was trying to help another resident be pushed in their wheelchair, but the resident in the wheelchair did not want to be pushed. The ADM stated that they were informed that the alleged perpetrator never touched the victim, and that staff discouraged the alleged perpetrator who walked away with no concerns. The ADM stated that as described, that incident was not reportable, but if she had all the facts, then she would have reported the incident. During an interview on 11/07/2025 at 8:28 AM, the ADM stated that she was not in the facility when the incident occurred between Resident #13 and Resident #14 but heard about it in the morning meeting. She stated that she was told that one resident was pushing the other resident in their wheelchair and that resident did not want to be pushed, so they were separated. She stated she was not aware of the resident being grabbed by the collar. She stated that if she had known the details, she would have investigated and reported it at that time.

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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 facility policy review, record review, facility document review, and interview, the facility failed to conduct a thorough investigation or maintain evidence of a thorough investigation. The facility also failed to protect residents from potential further abuse by allowing an alleged abuser to remain in the building. The deficiencies affected 6 (Residents #14, #15, #16, #4, #7, and #19) of 12 residents reviewed for abuse or resident-to-resident altercations during the complaint survey.Findings included: A facility policy titled, Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revised 11/06/2024, revealed, Reporting included, I. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies, which included, A. The State licensing/certification agency responsible for surveying/licensing the facility. The policy revealed, Abuse Investigating and Reporting, included, II. Supporting documents relative to alleged incident will be obtained, and III. The employee accused of alleged abuse will be immediately suspended and removed from the primacies [sic]. 1. An admission Record revealed the facility admitted Resident #9 on 01/31/2023. According to the admission Record, the resident had a medical history that included diagnoses of dementia, major depressive disorder, and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/28/2025, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #9 exhibited no physical or verbal behaviors during the assessment look-back period. Resident #9's Care Plan Report included a focus area revised 07/31/2024, that indicated the resident had inappropriate behaviors at times that included sitting on the floor and packing their clothing and sitting at the nurse station, stating that their family was coming to pick up the resident. Interventions directed staff to refer the resident to behavioral health services as indicated (initiated 10/31/2023). An admission Record revealed the facility admitted Resident #15 on 08/02/2019. According to the admission Record, the resident had a medical history that included a diagnosis of dementia. A quarterly MDS, with an ARD of 07/01/2025, revealed Resident #15 had a BIMS score of 2, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident exhibited no physical or verbal behaviors during the assessment look-back period. Resident #15's Care Plan Report included a focus area initiated 04/28/2024, that indicated the resident had a behavioral problem that involved wandering into other residents' rooms, related to dementia. Interventions directed staff to intervene as necessary to protect the rights and safety of others (initiated 04/28/2024 and revised 10/21/2024). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9's Progress Notes revealed a physician progress note, dated 9/18/2025 at 2:18 PM, that indicated the resident was examined after it was reported that the resident had attempted to dump another resident out of [his/her] wheelchair. Per the note, Resident #9 would not make eye contact or answer any questions but would only say that they wanted to go home. Resident #15's Progress Notes revealed a physician progress note, dated 9/18/2025 at 1:58 PM, that indicated the resident was examined after another resident had attempted to dump [Resident #15] from the wheelchair [the resident] was sitting in. Three documents titled, Witness Statement, each dated 09/14/2025, were provided by the facility related to the alleged incident between Resident #13 and Resident #14. During an interview on 10/09/2025 at 9:00 AM, the facility's current Director of Nursing (DON) stated she was unable to locate any additional evidence of an investigation regarding the alleged incidents between Residents #9 and Resident #15. During an interview on 10/13/2025 at approximately 9:00 AM, the DON stated that the alleged incident between Resident #9 and Resident #15 was not investigated due to the former DON telling her that it was not reportable. The DON stated that not investigating the alleged incident did not meet expectations. She stated that after an allegation of resident-to-resident abuse, she would expect an investigation to be completed. During an interview on 10/11/2025 at 9:22 AM, the Administrator (ADM) stated that resident-to-resident altercations fell under abuse, which were reportable. The ADM stated she was never informed of an altercation between Resident #9 and Resident #15. 2. An admission Record revealed the facility admitted Resident #16 on 09/27/2024. According to the admission Record, the resident had a medical history that included diagnoses of Hodgkin lymphoma, adult failure to thrive, chronic kidney disease, and hypertension. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/04/2024, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required supervision or touching assistance from staff for chair/bed-to-chair transfers, toilet transfers, and to ambulate 10 feet and 50 feet with turns. Resident #16's Care Plan Report included a focus area revised 01/16/2025, that indicated the resident had falls related to weakness. Interventions initiated 09/30/2024 directed staff to maintain a call light within reach when the resident was in their room and to reinforce the use of their call light. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A document titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Initial Report Form, dated 12/05/2024, revealed the facility reported an injury of unknown source. The report indicated that Resident #16 had left rib fractures of their seventh and eighth ribs. Per the report, the allegation details indicated that an X-ray was completed in the emergency room that showed acute rib fractures of the seventh and eighth ribs. The document further indicated that Resident #16 had sustained a fall in the facility on 11/10/2024 and had complaints of pain to their left rib/breast area with an X-ray completed that was negative for fracture. The document indicated that a second X-ray was completed on 11/14/2024 and was also negative for any fracture. A document titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report Form, submitted on 12/11/2024 at 5:30 PM, revealed the Medical Director concluded the X-ray results from 11/10/2024 and 11/14/2024 did not clearly show the area of the fractured seventh and eighth ribs and that there was probable cause that the rib fractures occurred from the resident's fall on 11/10/2024. The facility's investigation revealed no evidence of resident interviews, staff interviews, body audits of non-verbal residents, or any other evidence the facility conducted an investigation to ensure nothing had occurred between 11/10/2024 and 12/05/2024, when the fractures were identified. During an interview on 10/14/2025 at 2:34 PM, the Medical Director (MD) stated that he was able to determine the fractures from 12/05/2024 were from the fall on 11/10/2024 due to the fact Resident #16 had no other falls in that time period. He stated that rib fractures were notoriously hard to catch. The MD stated that realistically, the two sets of X-rays the facility obtained could have missed the fractures. He stated that when he found out Resident #16 was in the hospital with pneumonia and they had completed X-rays, he reviewed the films independently and there were signs of healing. He stated he could immediately tell they were subacute not acute, which meant they had signs of healing. The MD stated that he determined it was from the fall because of several factors, which included there being no suspicion of abuse and no resident-to-resident altercation. During an interview on 10/13/2025 at 11:24 AM, the former Director of Nursing (DON) (in the position at the time of the alleged incident) stated that Resident #16 was sent to the hospital and they discovered rib fractures. The former DON stated that she reported it to the state survey agency because the hospital reported it to her. The former DON stated that Resident #16 had a fall at the facility, and the facility obtained X-rays twice, but neither one indicated any fractures. She stated that she did not suspect abuse, but thought the fractures were a result of the fall. She stated that if she had suspected abuse, she would have conducted interviews and body audits of residents. During an interview on 10/14/2025 at 11:22 AM, the facility's current DON stated that she could not speak to the former DON's investigation, but that her expectation was to obtain statements from all staff that worked with Resident #16 and obtain statements from the resident if they had intact cognition, to determine if the resident was afraid or if anyone had been rough with the resident. She stated that she would review the previous 48 to 72 hours to see if anything had happened within the time frame the incident occurred. Per the DON, as for Resident #16, if they found the fractures on 12/05/2024, then she would review the timeframe prior to that. The DON reviewed the facility's investigation file and stated it was not a complete investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/15/2025 at 11:22 AM, the Administrator (ADM) stated that her expectation for the investigation of the self-reported incident related to Resident #16 was to report an unknown injury and start an investigation. She stated the facility should have assessed the alleged victim, assessed other residents, collected statements from staff that worked the shift during and the shift prior, even a few other days, to see if someone noticed anything. She stated that there should have been more interviews and assessments in the investigation for it to be complete and to rule out abuse. 3. An admission Record revealed the facility admitted Resident #4 on 12/11/2024. According to the admission Record, the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing) and aphasia (an inability to understand or produce speech) following cerebral infarction (a stroke), gastrostomy tube, chronic obstructive pulmonary disease (COPD), paroxysmal atrial fibrillation, atherosclerotic heart disease, and congestive heart failure. A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident did not exhibit any behavioral symptoms during the assessment timeframe. Per the MDS, the resident required maximal assistance from staff for activities of daily living (ADLs), including personal and oral hygiene, toileting, bathing, dressing, and putting on footwear. The MDS indicated the resident did not have any falls since admission, and the resident did not have a fracture related to a fall in the previous six months. Resident #4's Care Plan Report included a focus area initiated 12/13/2024, that indicated the resident had a self-care deficit related to cerebral infarction. Interventions dated 12/13/2024 directed staff to provide Resident #4 with assistance from two staff for walking and transfers, assist with repositioning, fall precautions, and indicated the resident utilized a wheelchair. A Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Initial Report Form, dated 12/17/2024, revealed the facility reported an incident of physical and mental/verbal abuse involving Resident #4, perpetrated by Licensed Practical Nurse (LPN) #3. The document indicated that the incident occurred at 1:02 AM on 12/17/2024. Per the document, two geriatric nursing assistants (GNAs), GNA #2 and GNA #4, witnessed LPN #3 being rude and rough with Resident #4 when assessing the resident for injuries after a fall. The report indicated that the GNAs reported the alleged abuse to LPN #6, who reported it to the facility's current Director of Nursing (DON), who was the Assistant Director of Nursing (ADON) at that time, who then reported it to the former DON (in the position at the time of the alleged incident). The report indicated that Resident #4 did not have serious bodily harm or injuries as a result of the alleged abuse. A Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Follow-Up Investigation Report Form, dated 12/23/2024, indicated, 3. Conclusion revealed, After the investigation of the incident the allegation has been verified. The report indicated that multiple staff members reported witnessing LPN #3 being rough, rude, and mean to Resident #4. The report indicated that staff seen and heard LPN #3 yelling and pulling on Resident #4's arm. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A typed statement included in the facility's investigation documents, dated 12/17/2024, from the DON, who was the ADON at the time of the incident, indicated that she received a call at 1:02 AM on 12/17/2024 from LPN #6 that Resident #4 had fallen. The statement indicated that while on the call, LPN #6 further informed the DON that GNA #2 and GNA #4 reported they observed LPN #3 being rude and rough during the resident's fall assessment. Per the statement, GNA #2 indicated that LPN #3 was pulling on the resident's arm and yelling at the resident to stop. Per the statement, GNA #4 indicated that when LPN #3 pulled a blood pressure cuff off the resident's arm, the nurse was rough and caused the cuff to break. The statement revealed the DON requested statements from staff and requested LPN #6 to observe for further concerns. There was no evidence that the DON provided instruction for LPN #3 to be suspended or removed from the premises. Resident #4's Neurological Evaluation Flow Sheet, dated 12/17/2024, revealed LPN #3's initials were on evaluations for 12:15 AM, 12:30 AM, 12:45 AM, 1:00 AM, 1:30 AM, and 2:00 AM. A document titled, Shifts Report, revealed LPN #3 clocked in to work on 12/16/2024 at 6:30 PM and clocked out on 12/17/2024 at 3:30 AM. During an interview on 10/09/2025 at 8:00 PM, LPN #6 stated that as soon as the GNAs notified her of the allegation of abuse, she immediately notified the DON because the DON was on call at that time. During an interview on 10/08/2025 at 4:47 PM, LPN #3 stated she continued to assess Resident #4 after the resident's fall. She stated she continued neurological evaluations of the resident until the DON arrived at the facility. She stated that she completed several neurological checks on Resident #4 after their fall. Per LPN #3, after the DON arrived, she (LPN #3) was told to finish her documentation work. She stated that she provided a written statement and then clocked out. During an interview on 10/13/2025 at 11:24 AM, the former DON (in the position at the time of the alleged incident) stated for staff-to-resident abuse, the alleged abuser should be sent off the premises immediately, and she thought LPN #3 was sent home immediately. She stated she could not remember who informed her of the abuse allegation or what transpired after allegation was reported. During an interview on 10/13/2025 at 1:21 PM, the facility's current DON (who was the ADON at the time of the alleged incident) stated that she arrived at the building at 2:15 AM and took the keys from LPN #3. The DON stated that LPN #3 did not clock out of work until 3:30 AM, and acknowledged Resident #4 was exposed to LPN #3 during neurological assessments until 2:00 AM. The DON stated she should have instructed LPN #6 to take LPN #3's keys and ask her to clock out. She stated that they determined that abuse did occur. During an interview on 10/13/2025 at 2:55 PM, the Administrator stated that for an abuse allegation, the alleged perpetrator should clock out and be sent home immediately. 4. An admission Record indicated the facility admitted Resident #7 on 04/09/2024. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety; polyosteoarthritis; other specified disorders of bone density and structure; and generalized muscle weakness. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/01/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #7 exhibited inattention and disorganized thinking. The MDS indicated Resident #7 had no functional limitations in movement of the upper extremities. According to the MDS, the resident was dependent on staff for bed mobility, moving from a sitting to lying position, and tub/shower transfers. Per the MDS, the resident required substantial/maximal assistance with lying to sitting on the side of the bed, moving from a sitting to a standing position, chair/bed-to-chair transfers, and toilet transfers. The MDS indicated the resident was able to walk 10 feet with partial/moderate assistance. The MDS also revealed that Resident #7's fall history on admission/entry or reentry included a fall in the previous month, a fall in the previous two to six months, and had a fracture related to a fall in the previous six months. Resident #7's Care Plan Report included a focus area initiated 09/19/2024, that indicated the resident had an alteration in their musculoskeletal status related to positive ulnar [the ulna bone is in lower arm and runs from the elbow to the wrist on the little finger side of the arm] variance. Interventions directed staff to make sure the call light was within the resident's reach, respond promptly to requests for assistance, and to educate the resident/family/caregivers on safety measures to reduce the risk of falls (initiated 09/19/2024). Resident #7's Care Plan Report also revealed a focus area initiated 04/10/2024, that indicated the resident had sustained falls with no injury, minor injury, or serious injury, related to poor balance and unsteady gait. Interventions directed staff to provide a perimeter mattress to the bed (initiated 03/10/2025). A Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Initial Report Form, dated 03/29/2025 at 12:32 PM, indicated that the facility reported an injury of unknown source related to Resident #7 having an acute distal fracture of the distal ulna. The report revealed that X-ray results received on 03/28/2025 revealed the injury. A Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report Form, submitted to the state survey agency on 04/02/2025, indicated that Resident #7 was in therapy on 03/27/2025 and was noted that the resident rubbed their left wrist. Per the report, when the resident's wrist was assessed, the wrist was noted to be red, tender, and swollen. The report revealed that the resident's provider also assessed the wrist and noted that when the resident's distal radius and ulna were palpated, the resident pulled away. Per the report, an X-ray was ordered, which revealed the resident had an acute fracture in the left distal ulna. The facility report revealed the facility staff interviewed therapy staff who observed concerns with the resident's wrist on 03/27/2025 and the nurse practitioner who assessed the resident. The report indicated that neither abuse nor neglect was verified. According to the report, Resident #7 had fallen on 03/10/2025 and was observed lying on their left side. The report revealed at the time of the fall that the resident had no complaints of pain. Per the report, on 03/18/2025, the resident was treated for cellulitis due to redness and swelling in the same area. The report indicated that Resident #7 had no complaints of pain until 03/27/2025. The report indicated that the Medical Director (MD), who was also the resident's primary physician, found the probable cause of the fracture occurred during the fall on 03/10/2025. The facility's investigation documents revealed no evidence of interviews with staff who provided care to the resident preceding the identification of Resident #7's injury. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 10/15/2025 at 9:18 AM, the MD stated that Resident #7's 03/28/2025 fracture was acute, and there was no way to connect Resident #7's 03/27/2025 fracture to the fall the resident sustained on 03/10/2025 (in contrast with the Facility Reported Incident Follow-Up Investigation Report Form). The PCP stated he did not think the origin of the ulna fracture was determined. During a telephone interview on 10/14/2025 at 10:20 AM, the Physician's Assistant (PA) stated that she was unable to give any insight into why Resident #7's 03/27/2025 left wrist fracture had been associated with the resident's 03/10/2025 fall. The PA stated that when the orthopedist read the X-ray, he was not even sure the ulna fracture was new. The PA stated that she had no insight into why Resident #7 had no complaints of pain or no deformity had been noticed prior to 03/27/2025. The Director of Nursing (DON) (who was the Assistant Director of Nursing [ADON] at the time of the alleged incident) was interviewed on 10/13/2025 at 10:15 AM. The DON stated that on 03/27/2025, Certified Occupational Therapy Assistant (COTA) #21 reported to her that Resident #7 was complaining of arm pain and the resident's arm looked different. The DON stated she assessed Resident #7's arm and found the arm to be painful, and a deformity was present in the lower forearm-wrist area of the resident's left arm. The DON stated the provider was in the building at the time, and the provider also assessed the resident and ordered an X-ray. The DON stated she was unsure how the conclusion was formed that the 03/10/2025 fall was responsible for the 03/27/2025 fracture. The DON stated she knew that therapy staff had treated Resident #7 prior to 03/27/2025 and had not reported that Resident #7 had problems with their arm. The DON stated the former DON (in the position at the time of the alleged incident) had been responsible for the investigation for Resident #7's fractured arm. COTA #21 was interviewed on 10/10/2025 at 2:55 PM. COTA #21 stated Resident #7 had been in the gym for therapy when their arm was noted to be painful. She stated that at the time of the discovery, the resident was working with physical therapy staff. COTA #21 stated that the last day she had treated Resident #7 was on 03/25/2025, and at that time, Resident #7 had no complaints of pain and no bruising, swelling, or decreased movement in the left wrist. The facility's current DON was interviewed on 10/15/2025 at 11:05 AM. The DON stated that the X-ray for Resident #7 revealed an acute fracture of the resident's wrist. The DON stated that the X-ray indicated that it was an acute fracture, meaning a new fracture and a fracture that was not in any stage of healing. The DON stated that the staff that had worked with Resident #7 in the shifts preceding the identification of the fracture should have been interviewed to complete a thorough investigation. The Regional Director of Operations (RDO) was interviewed on 10/15/2025 at 11:33 AM. The RDO stated that since Resident #7's wrist fracture had been identified as an acute fracture, the best practice for the facility would have been to interview staff that worked with the resident in the shifts preceding the identification of the fracture The Administrator (ADM) was interviewed on 10/14/2025 at 8:32 AM. The ADM stated that she had not been in the facility when the fracture to Resident #7's wrist was diagnosed. The ADM stated that the investigation of injury of unknown origin should have included interviewing staff that had worked with the resident in the days prior to the diagnosis of acute fracture to try to determine when Resident #7's pain started and the deformity appeared. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. An admission Record revealed the facility admitted Resident #19 on 11/06/2019. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and the membrane that cover it) affecting the left non-dominant side, recurrent major depressive disorder, difficulty in walking, alcohol-induced disorder, and other abnormalities of gait and mobility. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2025, revealed Resident #19 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated that the resident did not exhibit any physical or verbal behavioral symptoms directed at others. An admission Record revealed the facility admitted Resident #3 on 10/16/2024. According to the admission Record, the resident had a medical history that included diagnoses of early onset Alzheimer's disease, brief psychotic disorder, severe dementia with other behavioral disturbance, depression, generalized muscle weakness, difficulty in walking, and fatigue. An admission MDS, with an ARD of 10/24/2024, revealed Resident #3 had a BIMS of 4, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #3 exhibited physical and verbal behavioral symptoms directed toward others on one to three days during the seven-day look-back period. Per the MDS, the behavioral symptoms did not put others at significant risk for injury. The MDS also revealed that Resident #3 exhibited wandering behaviors on four to six days during the seven-day look-back period. According to the MDS, the wandering behavior did not intrude on the privacy or activities of others. Resident #3's Care Plan Report revealed a focus area initiated 10/18/2024, that indicated the resident had a cognitive decline related to dementia. The Care Plan Report also revealed a focus area initiated 10/18/2024, that indicated the resident was at risk for wandering or pacing. The resident's Care Plan Report also revealed a focus area initiated 11/22/2024, that indicated the resident was often aggressive and agitated with staff. Interventions directed staff to be alert of safety concerns to prevent injury to the resident or others (initiated 12/09/2024). Resident #3's Progress Notes revealed a note, dated 12/13/2024 at 4:10 AM, that revealed that at 7:30 PM, Licensed Practical Nurse (LPN) #37 was notified that Resident #3 was in Resident #19's room, and it appeared that Resident #3 was trying to choke Resident #19. The note indicated that Resident #3 was also observed pushing Resident #19's tray table against Resident #19's leg. Per the note, there were no injuries or bruises to Resident #19's neck or legs. The note revealed staff assisted Resident #3 to the hallway, gave the resident snacks, and administered medications until Resident #3 appeared to be ready to go to bed. The note indicated Resident #3 was assisted to bed by two staff members, and the resident slept during the night. Resident #19's Progress Notes revealed a Social Services note, dated 12/17/2024 at 10:44 AM, that indicated that Resident #19 was interviewed and stated that another pushed a table towards them and when Resident #19 told the other resident that they were in the wrong room, the other resident stated, Are you trying to be tough? The note indicated that Resident #19 stated that the resident came near them (Resident #19) but did not touch them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility-provided investigation documents related to the incident involving Resident #3 and Resident #19 revealed Residents #3's and Resident #19's respective admission Records, Resident #3's 12/13/2024 progress note, Resident #19's 12/17/2024 Social Services note, and a Witness Statement Form. The Witness Statement Form indicated that Resident #19 was interviewed by the former Director of Nursing (DON), who was in the position at the time of the alleged incident, regarding the incident of Resident #3 entering Resident #19's room. The facility's investigation documents revealed no evidence of statements from direct care staff, no evidence of the Administrator (ADM) being notified, no evidence that the incident was reported to the state survey agency, a description of the incident, an assessment of the residents, immediate interventions placed following the incident, or factors that predisposed to the incident. During an interview on 10/06/2025 at 4:12 PM, Resident #19 stated that they recalled the incident with Resident #3. Per Resident #19, they were lying on the bed when Resident #3 entered Resident #19's room and stated, Are you trying to start trouble? Be quiet. Resident #19 stated that Resident #3 tried to push Resident #19's tray table towards them (Resident #19). Resident #19 stated that was when Resident #19 pressed the call light, and staff came immediately and redirected Resident #3 out of the room. Resident #19 stated Resident #3 did not touch or attempt to choke them (Resident #19). During an interview on 10/09/2025 at 2:52 PM, LPN #37 stated that a geriatric nursing assistant (GNA) reported that Resident #3 attempted to choke Resident #19. LPN #37 stated she did not witness the incident; she only documented what the GNA reported. LPN #37 stated they assessed Resident #19, who had no injuries. LPN #37 stated she reported the alleged resident-to-resident abuse to the former DON and to the nurses on the following shift. During a telephone interview on 10/13/2025 at 3:42 PM, GNA #5 stated she reported the alleged attempt of Resident #3 to choke Resident #19 to a nurse. GNA #5 stated she went to Resident #19's room when she heard screaming from the resident. She stated that while at the doorway, she saw Resident #3 standing close to the head of Resident #19's bed and close to Resident #19's tray table. GNA #5 stated she saw Resident #3's hands raised, but she did not see Resident #3's hands directly close to or on Resident #19's neck. During an interview on 10/09/2025 at 6:31 PM, the former DON stated she vaguely remembered the allegation involving resident-to-resident abuse between Resident #3 and Resident #19. The former DON stated that she would have notified the ADM of the abuse allegation. She stated that she was unable to recall whether the abuse allegation was reported to the state survey agency. During an interview on 10/13/2025 at 12:21 PM, the facility's current DON stated that the alleged resident-to-resident abuse between Resident #3 and Resident #19 should have been thoroughly investigated to ensure resident safety. The DON stated that there should have been written statements from staff, and Resident #3 and Resident #19 should have been monitored. The DON stated that the investigation would have included identificati

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, facility policy review, and the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.19.1, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded for 1 (Resident #4) of 19 residents reviewed for accuracy of MDS assessments during the complaint survey.Findings included:A facility policy titled, Certifying Accuracy of Resident Assessment, revised 11/2019, revealed, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment.The CMS Long-Term Care Facility RAI 3.0 User's Manual, Version 1.19.1, dated October 2024 indicated:- Section J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA [Omnibus Budget Reconciliation Act] or Scheduled PPS [Prospective Payment System]), whichever is more recent, revealed, Code 0, no: if the resident has not had any fall since the last assessment, and Code 1, yes: if the resident has fallen since the last assessment, and- Section M0210; Unhealed Pressure Ulcers/Injuries, revealed, Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period, and, Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period.An admission Record revealed the facility admitted Resident #4 on 12/11/2024 and discharged the resident on 12/17/2024. According to the admission Record, the resident had a medical history that included diagnoses of dysphagia and aphasia following cerebral infarction (a stroke), chronic obstructive pulmonary disease, and congestive heart failure.Resident #4's Admit/Readmit Screener record, dated 12/11/2024, in Section C, Skin Integrity, revealed the resident had a pressure ulcer to the coccyx (tailbone) that measured 3 centimeters (cm) in length, 2 cm in width, and had no depth.Resident #4's Change in Condition record, dated 12/11/2024 at 6:15 PM, indicated the resident sustained a fall resulting in a skin tear that measured 1 cm by 1 cm to the right hand.A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had no falls since admission and no pressure ulcers. The MDS Section Z, Assessment Administration, listed the MDS Coordinator as the registered nurse coordinator who signed the assessment as completed on 12/18/2024.Resident #4's Skilled Progress Note[s], dated 12/12/2024 at 7:39 PM, indicated the resident had open areas on the coccyx and was followed by the wound care nurse.Resident #4's Care Plan Report revealed a focus area, initiated 12/13/2024, that indicated the resident had actual impairment to skin integrity due to a wound on the coccyx. Interventions directed staff to implement prescribed treatments and perform weekly skin assessments with wound documentation, 12/13/2024.Resident #4's Care Plan Report revealed a focus area, initiated 12/13/2024, that indicated the resident had a fall and was at risk for falls. Interventions directed staff to ensure proper use of devices as ordered and specified on the activities of daily living (ADL) care plan and provide verbal cues for safety as needed, 12/13/2024.During an interview on 11/03/2025 at 12:51 PM, the Director of Nursing (DON) stated that on 12/11/2024 at 6:15 PM Resident #4 experienced a fall that resulted in a skin tear to the right hand, and neurological checks (physical examinations to determine neurological function) were initiated following the incident.During an interview on 11/04/2025 at 10:42 AM, the MDS Coordinator stated that prior to completing the MDS assessment, a thorough review of the resident's medical record was conducted, including the hospital discharge summary, nursing assessments, therapy notes, and interviews with facility staff. The MDS Coordinator stated that Resident #4 sustained a fall on 12/11/2025, which was not coded in the MDS assessment but should have been. The MDS Coordinator stated that Resident #4's admission assessment mentioned a pressure ulcer but did not include a stage or description. The MDS Coordinator stated she should have clarified the pressure ulcer information with nursing staff so that it could have been coded. The MDS Coordinator acknowledged that the MDS for Resident #4 was not accurate and did not reflect the resident's actual status which had the potential to affect the resident's care and care planning.During an interview on 11/04/2025 at 2:24 PM, the DON stated that her expectation was for MDS assessments to be coded accurately through coordination with facility staff.During an interview on 11/04/2025 at 2:48 PM, the Administrator (ADM) stated that she expected the MDS staff to assess and code residents accurately as the MDS information affected resident treatment and care planning. The ADM stated MDS assessments should be completed in accordance with the facility's policy.

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Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, and interview, the facility failed to ensure staff accurately assessed a resident following a change in condition and failed to respond appropriately during the change of condition, which affected 1 (Resident #4) of 4 residents reviewed for abuse during the complaint survey. Findings included:A facility policy titled, Acute Condition Changes-Clinical Protocol, dated 03/2018, indicated, 7. Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician; for example, the history of present illness and previous and recent test results for comparison. a. Phone calls to attending or on-call physician should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. The policy also indicated, 8. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). The policy continued, 9. The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. a. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive timely or appropriate response.A facility policy titled, Change in a Resident's Condition or Status, dated 02/2021, indicated, 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the interact SBAR [Situation, Background, Assessment, Response] Communication Form.An admission Record revealed the facility admitted Resident #4 on [DATE] and discharged the resident on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing) and aphasia (a communication disorder) following cerebral infarction (a stroke), gastrostomy tube, chronic obstructive pulmonary disease (COPD), paroxysmal atrial fibrillation (occasional irregular heartbeat), atherosclerotic heart disease, and congestive heart failure (CHF).A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident did exhibit behavioral symptoms and required maximal assistance from staff for activities of daily living (ADLs), including personal and oral hygiene, toileting, bathing, dressing, and putting on footwear. The MDS revealed that no falls were recorded for the resident since admission, and the resident did not have a fracture related to a fall in the previous six months.Resident #4's Care Plan Report included a focus area initiated [DATE], that indicated the resident had an altered cardiovascular status related to hypertension, atrial fibrillation, cardiovascular disease, and indicated that the resident had a pacemaker. Interventions initiated [DATE] directed staff to monitor, document, and report as necessary any signs or symptoms of cardiovascular disease including chest pain, nausea and vomiting, shortness of breath, changes in capillary refill, and color/warmth of the resident's extremities.Resident #4's Care Plan Report revealed a focus area initiated [DATE], that indicated the resident required tube feeding related to dysphagia. Interventions initiated [DATE] directed staff to monitor, document, and report as necessary any signs or symptoms of aspiration, shortness of breath, tube dysfunction, abnormal breath/lung sounds, abdominal distention, pain, tenderness, and nausea or vomiting; and to keep the head of the resident's bed elevated at least 30 to 45 degrees.Resident #4's Care Plan Report revealed a focus area initiated [DATE], that indicated the resident had an alteration in hematological status related to anticoagulant (blood thinner medication) use. Interventions initiated [DATE] directed staff to complete a fall risk assessment and increase vigilance for falls, monitor, document, and report as necessary any signs or symptoms of anemia such as pallor, fatigue, dizziness, headache, shortness of breath on exertion, change in mental status, and weakness.Resident #4's Progress Notes revealed a note, dated [DATE] at 2:50 AM, that indicated that staff reported Resident #4 fell and was found on the floor, lying on their side on the right side of the bed. The note indicated that Resident #4 had vomited one time during the fall and one time after the fall. Per the note, the resident's tube feeding was not given due to vomiting. The note revealed no evidence that nursing staff auscultated the resident's lungs or assessed the resident's abdomen.Resident #4's SBAR Change in Condition, dated [DATE] at 2:54 AM and locked at 3:01 AM, revealed that Resident #4 had a fall from bed at 12:15 AM and Nurse Practitioner (NP) #29 was called at 12:40 AM. The record indicated that NP #29 had not returned the call at that time. Per the

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on facility policy review, record review, facility document review, interview, and observation, the facility failed to ensure the residents' environment remained as free of accident hazards as possible, which affected 4 (Resident #8, #7, #12, and #18) of 9 residents reviewed for accidents or falls during the complaint survey. Specifically, Resident #8 was improperly transferred by one staff when they required two staff to safely transfer causing actual harm. The Findings include: A facility policy titled, Assessing Falls and Their Causes, revised 03/2018, revealed, The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy revealed, Preparation included, 1. Review the resident's care plan to assess any special needs of the resident. The policy revealed, Identifying Causes of a Fall or Fall Risk specified, 2. Evaluate chains of events or circumstances preceding a recent fall, including: a. Time of day of the fall; b. Time of the last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; e. Whether the resident was among other persons or alone; f. Whether the resident was trying to get to the toilet; g. Whether any environmental risk factors were involved (e.g. [exempli gratia; for example], slippery floor, poor lighting, furniture or objects in the way); and/or h. Whether there is a pattern of falls for this resident. 1. An admission Record revealed the facility originally admitted Resident #8 on 12/11/2024 and readmitted the resident on 03/01/2025. According to the admission Record, the resident had a medical history that included diagnoses of generalized muscle weakness, difficulty walking, fatigue, and congestive heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/19/2025, revealed the Resident #8 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance to transfer from a chair to a bed. Resident #8's Care Plan Report included focus area dated 12/13/2024, that indicated Resident #8 had an activities of daily living (ADLs) deficit related to confusion and forgetfulness and was alert and oriented to person only. Interventions directed staff to provide two staff to assist the resident with transfers (initiated 12/13/2024). Resident #8's Kardex [a guide for direct caregivers outlining each resident's care needs] Report as of 3/31/2025, documented Resident #8 assistance from two people for transfers. A Maryland Department of Health Office of Health Care Quality Facility Reported Incidents Initial Report Form revealed that the facility reported to the state survey agency that Resident #8 had a laceration to left lower leg outer aspect that the facility reported as an injury of unknown source. The report indicated that the Director of Nursing (DON), who was the Assistant Director of Nursing (ADON) at the time, became aware of the injury on 04/01/2025 at 9:45 AM. The report indicated that the DON submitted the report to the state survey agency on 04/01/2025 at 12:45 PM. Per the report, all beds in the facility were inspected by maintenance staff to ensure there were no sharp edges and indicated that any issues that were identified were fixed immediately by maintenance staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report, submitted to the state survey agency on 04/07/2025, revealed Geriatric Nursing Assistant (GNA) #19 was transferring Resident #8 when the resident stated that their leg hurt. The report indicated that there was probable cause that the laceration occurred from the resident's leg hitting against an uncapped edge of their bed frame when the resident was being transferred to bed. Per the report, the resident required 15 sutures to the laceration. The report indicated the GNA #19 was suspended, pending investigation. Resident #8's New Skin Concern record, dated 04/01/2025 at 12:00 AM, indicated that Licensed Practical Nurse (LPN) #20 was called to Resident #8's room by GNA #19 related to the resident's left leg bleeding. The record indicated Resident #8 was in bed, alert, with an open gash on the left leg. The record indicated the nurse applied pressure, cleansed the wound, and applied a dressing. The record indicated Resident #8 was unable to give a description of what had happened, and a nurse was asked to call 911. Resident #8's hospital Patient Visit Information, dated 04/01/2025, indicated that the resident had a laceration on their left lower leg, with a component of skin avulsion. Per the record, This means that the skin was torn off. As such, the edges are not perfectly sewn together. A Witness Statement, dated 04/01/2025 and signed by GNA #19, revealed that on 04/01/2025 at 12:00 AM, GNA #19 transferred Resident #8 to bed. The statement revealed that after the GNA got the resident in bed, the resident stated, Ouch, my leg hurts. The statement indicated that when GNA #19 looked, she saw the cut and blood and also saw blood and skin in the bedframe. Per the statement, she reported it to the nurses. A Witness Statement, dated 04/01/2025 and signed by LPN #1 revealed that a GNA assigned to Resident #8 reported that the resident complained of pain after being transferred from their wheelchair to their bed. The statement indicated that LPN #1 noted blood and skin tissue inside of an un-capped bed frame [sic] edge. During an interview on 10/12/2025 at 4:24 PM, GNA #7 stated that she and another orientee found Resident #8 with a tube feeding pole that had fallen over the resident's shoulder. GNA #7 stated that a nurse did a complete head-to-toe assessment on the resident at that time, and they did not see any blood or a cut on the resident. GNA #7 stated that she recommended to GNA # 19 that the resident should be put to bed, and shortly after that she heard GNA #19 yelling that Resident #8 caught their leg during when being transferred, and the resident was bleeding. GNA #7 stated she told GNA #19 to get the nurse. GNA #7 stated the GNAs knew how to transfer a resident by checking the Kardex. During an interview on 10/11/2025 at 8:15 PM, GNA #8 stated that she was an orientee with GNA #7 on the night Resident #8 hurt their leg. She stated that before that happened, she noticed the resident had wheeled away from their tube feeding pole and it fell across the back of the wheelchair and the resident's shoulders. She stated that they straightened the resident and the pole and notified the nurse. She stated they did not transfer the resident but notified the resident's GNA (GNA #19) that the resident was moving around. She stated that there was no bleeding or a cut noted on the resident when she saw them. She stated GNAs followed the care plan in the Kardex to know how to transfer a resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/12/2025 at 4:49 PM, LPN #20 stated that she was called to Resident #8's room by two GNAs when the resident's pole for the tube feeding fell on the resident's shoulder. LPN #20 stated that she looked the resident over from head to toe, and there were no marks and no bleeding. LPN #20 stated that the two GNAs asked the resident's GNA (GNA #19) to move the resident to bed. LPN #20 stated GNA #19 notified her and informed her that Resident #8's leg was bleeding, and she had the charge nurse accompany her to the resident's room. LPN #20 stated she and the charge nurse noted blood on the resident's bed frame, and no blood on the resident's wheelchair. LPN #20 stated the GNAs should know how to transfer a resident by using the Kardex. During an interview on 10/15/2025 at 2:03 PM, the Director of Nursing (DON) stated that the GNA should have gotten assistance to transfer the resident. The DON stated that Resident #8 required two people to assist with transfers, and stated that they fired the GNA because she did not follow the care plan. 2. An admission Record indicated the facility admitted Resident #7 on 04/09/2024. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety; polyosteoarthritis (arthritis affecting multiple joints simultaneously); other specified disorders of bone density and structure; and generalized muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/01/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #7 had inattention and disorganized thinking. The MDS indicated Resident #7 had no functional limitations in movement of the upper extremities but had bilateral limitations in range of motion of the lower extremities. The MDS indicated Resident #7 was dependent on staff for rolling left and right while lying in bed, moving from sitting to lying, and for tub/shower transfers. The MDS indicated Resident #7 required substantial/maximal assistance with moving from lying to sitting on the side of the bed, moving from sitting to a standing position, for chair-to-bed and bed-to-chair transfers, and for toilet transfers. The MDS indicated Resident #7 was able to walk 10 feet with partial/moderate assistance from staff. Per the MDS, Resident #7's fall history revealed the resident had fallen in within the month prior to admission or re-entry, experienced a fall in the previous two to six months prior to admission/entry or reentry, and had a fracture related to a fall in the six months prior to admission or re-entry. Resident #7's Care Plan Report included a focus area, initiated 04/10/2024, that revealed Resident #7 was at risk for falls related to a history of falls, poor balance, and an unsteady gait. Interventions included instructions for staff to do the following: - Ensure the call bell/light was within reach, encourage the resident to use the call light, and respond promptly to the resident's requests for help (initiated 04/10/2024); - Provide increased visual cue in room (initiated 09/12/2024); and - Frequently re-orient the resident and reinforce the need to call for assistance (initiated 04/10/2024). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #7's Care Plan Report included a focus area initiated 09/19/2024, that indicated the resident had an alteration in their musculoskeletal status. Interventions initiated 09/19/2024 directed staff to ensure the call light was within the resident's reach and respond promptly to requests for assistance (this was a repeated intervention that was already initiated 04/10/2024), and to educate the resident/family/caregivers on safety measures to reduce the risk of falls. Resident #7's Care Plan Report included a focus area initiated 04/10/2024, that indicated the resident had a fall on 02/06/2025 that resulted in a skin tear to the left hand, and a fall on 02/18/2025 from their bed that resulted in a skin tear to the left elbow. Interventions directed staff to do the following: - Assess the resident after each fall and ensure safety, ensure eating was done in staff sight, and keep the call light in reach (initiated 04/10/2024); - Monitor the resident more closely when out of bed at night (initiated 04/27/2024); - Offer more frequent checks to minimize falls (initiated 05/24/2024); - Provide visual cue in the resident's room to remind the resident to ask for assistance when getting out of bed (initiated 07/08/2024); - Place the resident at a table when a snack is given (initiated 10/16/2024): - Attempt to monitor the resident's whereabouts and redirect for safety as needed (initiated 04/02/2025); - Educate the resident of the importance of transfer assistance and the dangers of transferring independently (initiated 04/28/2024); and - Keep the resident in sight when the resident was antsy [anxious]/wanting to assist/clean (initiated 05/21/2025). Resident #7's Kardex (an electronic form used by the geriatric nursing assistants [GNAs] to direct resident care), dated 10/09/2025, revealed, Fall Prevention, which included the following directions to staff: Ensure the resident's call light was within reach, encourage the resident to use it for assistance as needed and respond promptly to all requests for assistance, educate the resident on the importance of transfer assistance and the danger of transferring independently, frequently re-orient and repetitively reinforce the need to call for assistance, keep the call bell in the resident's reach (this was already previously mentioned), offer more frequent checks to minimize falls, monitor the resident more closely when out of bed at night, and provide verbal cues for safety. The Kardex revealed the Resident Care section included staff directions to ensure call light was in reach and respond promptly to all requests for assistance and ensure the resident had a table in front of them for snacks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility incident report dated 02/22/2025 at 12:00 AM, revealed Resident #7 was found on the floor in front of their wheelchair in their room. The report indicated Resident #7 had been reaching for a tissue, slid to the floor, did not hit their head, and had no injury. The report revealed sections for Predisposing Environmental Factors, Predisposing Physiological Factors, and Predisposing Situation Factors. The report revealed that each of those sections were blank. Resident #7's Progress Notes revealed a note, dated 02/24/2025 at 1:40 PM, that indicated the Interdisciplinary Team (IDT) met two days after Resident #7's fall to discuss the fall. The note indicated that Resident #7's care plan was updated to keep personal items, tissues, and water on their overbed table within reach. Resident #7's Care Plan Report revealed an intervention initiated 02/24/2025, that directed staff to ensure the resident's personal items were in reach on their overbed table (initiated 02/24/2025). A facility incident report, dated 03/02/2025 at 2:22 PM, indicated Resident #7 was found in their room on the floor, sitting in front of their wheelchair. Resident #7's Progress Notes revealed a note, dated 03/02/2025 at 2:22 PM, that indicated Resident #7 was assessed after the fall, assisted to their wheelchair by staff, and the care provider and the resident's power of attorney were notified of the fall. Resident #7's Progress Notes revealed a note, dated 03/03/2025 at 2:36 PM, that indicated the IDT met concerning the resident's fall and added a new intervention to place the resident at the nurses' station between meals and activities for supervision and safety. Resident #7's Care Plan Report revealed an intervention initiated 03/02/2025, that directed staff to provide supervision for the resident at the nurses' station between meals and activities (initiated 03/02/2025). The record revealed no investigation or witness statements included to determine how long the resident had been in the room alone or what the resident had been doing prior to the fall. A facility incident report, dated 03/10/2025 at 6:45 PM, indicated Resident #7 was found in their room lying on the left side in front of their wheelchair, an old skin tear was reopened on their left forearm, and a new skin tear was found on their left knee. The report indicated Resident #7 was assessed, the resident's left knee and left forearm were cleansed, a dressing was applied, and a family member and care provider were notified of the fall. Resident #7's Progress Notes revealed a note, dated 03/11/2025 at 11:36 AM, that indicated the IDT met concerning the resident's fall and added the intervention of a perimeter mattress to the bed (although the resident was found in front of their wheelchair). Resident #7's Care Plan Report revealed an intervention initiated 03/10/2025, that directed staff to ensure a perimeter mattress was used on the resident's bed (initiated 03/10/2025). The record revealed no evidence of an investigation to determine the cause of the fall and no witness statements that indicated where the resident had been prior to being found on the floor in front of the wheelchair or when care was last received. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility incident report, dated 04/20/2025 at 8:00 PM, indicated Resident #7 was eating a snack while sitting in the wheelchair, dropped the snack, and fell out of the wheelchair while bending over to pick up the snack. The report indicated Resident #7 was assessed, was at their baseline with no pain, and a family member and care provider were notified. Resident #7's Progress Notes revealed a note, dated 04/21/2025 at 2:48 PM, that indicated the IDT met concerning the resident's fall and added a new intervention to ensure the resident had a stand in front of them at snack time. Resident #7's Care Plan Report revealed an intervention initiated 04/20/2025, that indicated that re-education was provided to staff to keep a table in front of the resident during snacks. The record revealed a Post Fall Huddle (PFH [meeting of staff members after a resident fall]) Fall Scene Investigation Form that revealed no information about when the resident had last received care. The record also revealed staff statements related to the fall. A facility incident report, dated 06/13/2025 at 4:45 PM, indicated that Resident #7 was found on the bathroom floor in the dining room, sitting with their back against the wall near the sink. The report indicated that Resident #7 stated that they took themself to the bathroom and fell when transferring back to their wheelchair and the wheelchair kept moving away. The incident report revealed the resident was assessed, assisted with toileting, assisted to their wheelchair, and taken to the nurses' station. A Post Fall Huddle (PFH) Fall Scene Investigation Form, dated 06/13/2025 at 4:45 PM, revealed Resident #7 had transferred independently in the dining room bathroom, the resident was last seen at 3:45 PM, and Current Interventions in place at the time of the fall was listed as unknown. Resident #7's Progress Notes revealed a note, dated 06/16/2025 at 5:16 PM, that indicated the IDT met concerning the resident's fall and added a new intervention to ensure staff brought Resident #7 out of the dining room after activities (the intervention did not address stopping the wheelchair from rolling backwards should Resident #7 attempt self-transfer again). Resident #7's Care Plan Report revealed an intervention initiated 06/13/2025, that directed staff to remove the resident from the dining room when activities were over. The record revealed no witness statements that revealed why the resident was in the dining room bathroom alone or when the resident had last received care or by whom. A facility incident report dated 07/22/2025 at 5:00 PM, indicated Resident #7 had an unwitnessed fall in the dining room while waiting for dinner to be served. The report indicated that the resident was assessed, skin tears were observed on the resident's right lower arm and left knee, the tears were cleansed and ointment and dressings were applied to the tears, the resident was taken to the nurses' station to sit with staff, and the resident stated that they knew they could not walk, but wanted to try. Resident #7's Progress Notes revealed a note, dated 07/23/2025 at 2:02 PM, that indicated the IDT met concerning the resident's fall and added a new intervention for a psychiatric medication evaluation related to increased anxiety and fidgeting. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #7's Care Plan Report revealed an intervention initiated 07/22/2025, that directed staff to provide a medical evaluation related to increased anxiety/fidgeting. The record revealed no staff statements as part of the investigation. A facility incident report, dated 08/02/2025 at 7:45 PM, indicated Resident #7 was sitting in their wheelchair at the nurses' station; the resident leaned forward, and the resident fell out of the wheelchair onto the right side of their face. The report indicated Resident #7 sustained an abrasion to their right knee and a hematoma to the top of their scalp. The report indicated that Resident #7 was assessed and sent to the emergency department. The report revealed sections for Predisposing Environmental Factors, Predisposing Physiological Factors, and Predisposing Situation Factors. The report revealed that each of those sections were blank. Resident #7's ED [Emergency Department] Provider Documentation record, dated 08/02/2025, revealed, Findings: There is osteopenia or osteoporosis. There appears to be smoothly-marginated deformity at the distal clavicle, possibly related to fracture, age uncertain. An acute fracture is not totally excluded. The appearance could also be related to suboptimal positioning. Pending clinical correlation, a dedicated complete examination of the shoulder and clavicle should be considered. Otherwise, no fracture or dislocation is demonstrated. Impression: 1. Limited exam 2. Query fracture deformity at the distal clavicle, age uncertain. The record indicated that a sling was placed for a possible distal clavicle fracture. Resident #7's Progress Notes revealed a note, dated 08/04/2025 at 1:50 PM, that indicated the IDT met concerning the resident's fall and added a new intervention for an antibiotic for a urinary tract infection (UTI) as ordered. Resident #7's Care Plan Report included a focus area initiated on 08/04/2025, that indicated the resident had a right clavicle (collarbone) fracture. Interventions initiated 08/04/2025 directed staff to ensure the resident's call light was in reach and respond promptly to requests for assistance (this was a repeated intervention that was originally initiated on 04/10/2024), educate resident/family/caregivers on safety measures to reduce the risk of falls (this was a repeated intervention that was originally initiated on 09/19/2024), and provide antibiotic treatment of a urinary tract infection UTI as ordered. During an interview on 10/15/2025 at 1:20 PM, the Medical Director (MD) stated Resident #7's clavicle fracture was treated as acute but was most likely an old fracture or other anomaly according to the radiology report. During an interview on 10/10/2025 at 8:30 PM, LPN #9 stated she witnessed Resident #7's fall. LPN #9 stated she was in the 400 Hall and looked toward the nurses' station and saw Resident #7 lean forward and land on their face. LPN #9 stated Resident #7 had a bruise on their forehead. LPN #9 stated that sometimes, a nurse could watch the people who were sitting in front of the nurses' station, but if a nurse was charting, then they were trying to do two things at once. LPN #9 stated that nobody was assigned to watch the residents at the nurses' station, and it was everyone's job. LPN #9 stated if a resident was a high fall risk, she took the resident with her or kept them closer to her if she had to go down the hall. LPN #9 stated she did not take Resident #7 with her that shift because the resident was talking with other residents. LPN #9 stated Resident #7 always tried to climb out of their chair, and no interventions were really effective. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 10/09/2025 at 10:12 AM, Resident #7 was observed sitting in their wheelchair in their room. GNA #25, who was initially in the room, stepped out of the room and left the resident alone. When Resident #7 was asked what it meant to remember to call for assistance, the resident stated, It means to pray. When GNA #25 returned, she gave Resident #7 their call light and gave the resident instructions to press the bell. Resident #7 held the call light up to their face and stated that no one was answering. Resident #7 was unable to find the place on the call light to push for assistance. On 10/09/2025 at 10:15 AM, Resident #7 was observed alone in their room, sitting in their wheelchair, trying to remove their brief with their gown pulled up above their waist, and trying to get up several times. At 10:19 AM GNA #25 returned to Resident #7's room and admitted she was not supposed to leave the resident alone when the resident was sitting in their wheelchair because the resident would undress and try to get up. GNA #25 stated she had gone to get clean linen and then answered another resident's call light. GNA #25 stated she could have asked another staff member to get the linen for her and to answer the other call light. GNA #25 was interviewed on 10/09/2025 at 3:07 PM. GNA #25 stated she should not have left Resident #7 alone in their room while in the wheelchair and the next time she planned to change the resident's linens, she would take the linen with her, activate the call light for someone to bring the needed items, or place Resident #7 in the hallway where the resident was observed. GNA #11 was interviewed on 10/09/2025 at 2:38 PM. GNA #11 stated Resident #7 was unable to remember instructions, unable to use a call light, confused, and thought they were at their home. During an interview on 10/09/2025 at 6:51 PM, GNA #11 stated that they were supposed to watch Resident #7 at all times because the resident could not stand but would try to. GNA #11 stated that if she had to take care of another resident, she took Resident #7 to the nurses' station to be watched. GNA #11 stated there was not always someone at the nurses' station as, at times, those staff members had to leave to take care of residents. During an interview on 10/11/2025 at 8:15 PM, GNA #8 stated that if Resident #7 saw something on the floor, the resident would bend down to pick it up. GNA #8 stated that it was usually an effective intervention to place residents near the nurses' station. GNA #8 stated that if the aides were busy, nurses had the aides bring residents who were high fall risks behind the nurses' station to be next to the nurses while the nurses charted at the desk. GNA #8 stated that during medication administration, when nurses had to go to the floor, at times residents were left alone in front of the nurses' station and no staff were assigned to be with them. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Licensed Practical Nurse (LPN) #17 was interviewed on 10/09/2025 at 10:29 AM. LPN #17 stated that she was the primary day shift nurse for Resident #7. LPN #17 stated that when a resident fell, the assigned nurse was expected to complete all the paperwork, and it was important to complete all sections of the incident report to capture all the details of the fall. LPN #17 stated the assigned nurse was expected to get statements from all staff that were working with the resident at the time of the fall and to gather information about when the resident was last seen and provided care. LPN #17 stated that the assigned nurse at the time of the resident's fall was also responsible for organizing and initiating the Post Fall Huddle (PFH) Fall Scene Investigation Form and that it was important to know what interventions were in place for the resident at the time of the fall and to determine what caused the fall. LPN #17 reviewed the documentation for Resident #7's fall on 02/22/2025 and stated she had no reason to give as to why she did not fully complete the incident report. LPN #17 stated the incident report painted a picture of the fall, and from her documentation, she had not painted a very pretty picture. LPN #17 stated the time at the top of the report was to identify the time the fall had occurred, but she had not worked at midnight, so the form was inaccurate. The LPN described Resident #7 as fidgety and stated that the resident should not be left in a room alone and had no explanation as to why the resident had been alone in the room. LPN #24 was interviewed on 10/09/2025 at 11:55 AM. LPN #24 stated that it was important to complete an incident report to document any injuries in case an injury was found later; it would be already documented in the prior assessment. LPN #24 stated the assigned nurse was responsible for documentation about when the resident was most recently seen, what they were doing prior to the fall, and to gather witness statements. LPN #24 stated a picture was drawn on the Post Fall Huddle (PFH) Fall Scene Investigation Form and a written description of how the resident was found, including which side the resident was on, if there was environmental issues contributing to the fall, if the resident was continent or incontinent, and what kind of shoes the resident had on at the time of the fall. LPN #24 stated witness statements were obtained from assigned staff and the person that found the resident. LPN #24 stated that the assigned nurse was also responsible for the Post Fall Huddle (PFH) Fall Scene Investigation Form. LPN #24 stated she was familiar with Resident #7. LPN #24 stated Resident #7 was a high fall risk, and the resident was not to be left in their room alone when up in their wheelchair, that directive had been communicated to all staff, and she had passed the information to all GNAs on her shift. LPN #24 stated she was sure that GNA #25 was aware not to leave Resident #7 alone in their room when up in the wheelchair since GNA #25 provided care to Resident #7 daily. LPN #24 stated that the visual cues in Resident #7's room (initiated as an intervention on 07/08/2024 and 09/12/2024) were of no benefit to the resident since the resident was independent and thought they could still stand. LPN #24 stated Resident #7 was unable to comprehend the visual cues, and she had discussed the lack of comprehension with other staff. LPN #24 stated that using education or reminders for Resident #7 (initiated as an intervention on 09/19/2024) was not an effective intervention since the resident had impaired memory. LPN #24 stated Resident #7's roommate tried to take care of Resident #7, which aggravated the resident and would make Resident #7 try to get up and away from the roommate. LPN #24 stated she had communicated that concern to the Assistant Director of Nursing (ADON), the former Director of Nursing (DON), and the current DON. The LPN stated that even after telling the administrative nurses, no one had mentioned changing the resident's room to decrease the aggravation. During an interview on 10/10/2025 at 11:18 AM, LPN #10 stated the nurses' station was not always staffed, and if the nurses had to administer mediations, they asked the GNAs to keep eyes on the residents. LPN #10 stated Resident #7 should never be left alone in their wheelchair because they would attempt to walk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Registered Nurse (RN) #26 was interviewed on 10/08/2025 at 3:05 PM. RN #26 stated that it was important to fully complete an incident report so leadership would know what caused the fall, and so they could choose interventions to prevent further falls. RN #27 was interviewed on 10/10/2025 at 2:06 PM and stated that in addition to a physical assessment after a fall, she was expected to ask the resident what happened to make them fall. RN #27 stated that if the res

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on facility document review and interview, the facility failed to ensure their Quality Assurance Performance Improvement (QAPI) program effectively implemented a plan to address quality deficiencies identified related to falls. This deficient practice affected 3 (Residents #7, 12, and #18) of 9 sampled residents reviewed for accidents during the complaint survey.Findings included:The facility's QAPI meeting documentation from June 2025 to September 2025 indicated that falls were reviewed each of the months. The documents revealed that in May, the facility documented that there were 25 falls with 22 residents and that two of the residents accounted for five of the falls. A review of the facility's documents revealed no evidence of corrective actions being developed to address the concern nor evidence of a good faith effort to address the concerns.During an interview on 10/15/2025 at 3:54 PM, Registered Nurse (RN) #26 stated that she had never been to a QAPI meeting and had never been asked to contribute to a performance improvement project (PIP). She stated that there were papers that listed falls by shift at the nurses' station, but no one had asked for her opinion or suggestions on how to decrease falls.During an interview on 10/15/2025 at 4:00 PM, Licensed Practical Nurse (LPN) #38 stated that she had never been asked to participate in QAPI. She stated that she had been asked for suggestions to decrease falls on the secured unit for specific residents, but not in development of a PIP with goals and outcomes.During an interview on 10/15/2025 at 11:14 AM, the Director of Nursing (DON) stated that falls had been identified as a concern and were being discussed in QAPI meetings. She stated that there was a weekly fall meeting with administrative staff and the interdisciplinary team (IDT) and discussion in morning meetings where the facility staff reviewed risk incident reports. She stated that for an identified concern, she expected a written action plan that showed the identified problem and ways the facility was trying to fix it, with tools like audits, metrics to meet, and ways to determine if interventions were effective. She stated that if one was drafted somewhere, she was not involved in the follow up or action items.The Administrator (ADM) was interviewed on 10/11/2025 at 9:50 AM. The ADM stated that she noticed falls were high about six months prior, when she first started at the facility. She stated that one intervention discussed included frequent and constant rounds, but she ran into push back from the former DON (in the position at the time of the discussion of frequent and constant rounds). She stated that the standard was two hours, but she expected more. She stated that the corrective action plan for falls was verbally relayed to staff, but there was no written plan. She stated her main focus related to falls was to reduce the number of falls and then when the numbers of falls started declining, the plan was to assess other parts of the fall policy to see if there were other issues. She stated staff did daily angel rounds, which were documented where department managers were to discuss what they had found, including any fall risks identified.During a follow up interview on 10/15/2025 at approximately 12:00 PM, the ADM stated that her expectation for an identified concern with falls for QAPI was for there to be a plan. She stated that they needed to talk about the concern and put interventions in place. In regard to whether there should be a written plan with steps to follow and tools to measure effectiveness, the ADM stated that she expected the fall protocol to be followed and to change things that did not work. The ADM stated that if the falls continued to happen, then they would try a new intervention. In regard to how staff tracked interventions the facility had tried, she stated they discussed the concern in morning meetings and made corrections on an individual basis. She stated that they were implementing angel rounds and increased monitoring facility wide.