STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215278	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Meadows Retirement Com.	11630 Glen Arm Road Glen Arm, MD 21057

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on review of the facility's investigation file and medical records and interview with facility staff, it was determined that the facility failed to ensure a resident remained free of abuse. This was evident for 1 (Resident #18) of 4 residents reviewed for abuse during the recertification/complaint survey. The findings include: The facility's investigation file related to facility reported incident MD#00209055 was reviewed by the surveyor on 3/24/2025 at 4:00 PM. Review of facility reported incident MD#00209055 revealed the following: On Friday, 8/23/2024 at approximately 7:30am Staff #4 observed Resident #18 reach for a laundry basket and Geriatric Nursing Assistant (GNA #25) allegedly open hand smacked Resident #18 on her left forearm. Included in the investigation file was a document titled, Interview Questions for the Facility Abuse Coordinator and had Staff #4's name and title along with the date and time (8/23/24 at 9:53 AM) that documented, at approximately 7:30 AM on 8/23, I [Staff #4's first and last name] saw GNA [#25] smack the left forearm of resident, [Resident #18's first and last name]. Resident #18 was in hallway outside [room] 152. Resident #18 reached for laundry basket; GNA [#25] then smacked Resident #18 on left forearm to get the resident to let go of the basket. Additionally, this document was signed by the DON as the interview witness. Furthermore, a documented interview with Resident #18 was included in the investigation file. The interview was conducted in the DON's office by the DON and Assistant Director of Nursing (ADON) following the reported allegation on 8/23/24 at 10:45 AM. When asked if anything concerning happened to him/her [Resident #18] this morning while receiving care, Resident #18 held his/her left hand in the air and demonstrated a swiping motion. When asked if s/he was implying that s/he was hit, Resident #18 nodded his/her head and grabbed her left arm. Staff #4 was interviewed on 3/26/25 at 8:25 AM. During the interview when asked to share what s/he remembered about the incident with Resident #18 and GNA #25 on 8/23/24 s/he stated, it was a quick second. GNA #25, was walking out of a resident's room pushing a metal laundry basket and Resident #18 was sitting in his/her wheelchair. S/he tends to grab things and reached out for the laundry basket and would not let go and GNA #25 smacked his/her left forearm. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Abuse Neglect Exploitation was reviewed on 3/36/24 at 8:50AM and revealed, It is the policy of Presbyterian Senior Living facilities that each resident is provided with a safe environment where they are not subject to mental, physical, verbal, and sexual abuse. Residents shall also be protected from mistreatment, neglect, exploitation, and misappropriation of property. Additionally, the definition of physical abuse noted in the policy stated, Physical Abuse: Includes but is not limited to hitting, slapping, pinching, and kicking. The DON and NHA were interviewed on 3/27/25 at 9:04 AM regarding the incident on 8/23/24 with Resident #18 and GNA #25. During the interview the surveyor stated there were several interviews in the facility's investigation file that was provided to the survey team on 3/24/25 that documented that Resident #18 was smacked. When asked if the GNA smacking the resident was abuse he stated, this is where we get into intentionality. We had a panel call (a phone call involving corporate staff) and the question was, did that employee, GNA #25, willfully abuse Resident #18. He stated he struggled with that question, and what we (on the panel call) talked about was did she [GNA #25] intentionally do that [smack the resident]. The surveyor again shared concerns regarding the incident and the DON then stated and that is why we terminated that employee. Additionally, he stated, Certainly, as the DON it is my goal to keep residents safe. I certainly do not think that behavior [smacking] has any place in senior care anywhere. At the end of the day, I was not going to have this employee work here to have this opportunity to happen again. On 3/27/25 at 9:09 AM in an interview with the NHA regarding GNA #25 and Resident #18 he stated on the panel call the discussion all around was: was there the willful intent [from GNA #25] to hurt [Resident #18]. During the interview the NHA stated, It is a fine line, and I do not think the intent was to hurt. The surveyor continued to share concerns about the incident. When asked yes or no, if you witnessed a GNA smacking a resident is that abuse, the NHA stated, He could not say yes or no. It depends on the intent. I struggle with this one knowing the resident. I think the way she [GNA #25] provided care was wrong, but I do not think she had an intent to hurt the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49304 Based on review of facility reported incidents, record review, and interview with staff, it was determined that the facility failed to timely report allegations of abuse to the State Survey Agency, the Office of Health Care Quality (OHCQ). This was evident for 2 (Resident #18 and #11) of 4 residents reviewed for abuse during the recertification/complaint survey. The findings include: The OHCQ is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse, serious bodily injury, and misappropriation of resident property are to be reported to the OHCQ in a timely manner (within 2 hours for the initial report and within 5 working days for the final report). 1) The facility's investigation file related to facility reported incident MD#00209055 was reviewed by the surveyor on 3/24/2025 at 4:00 PM. Review of facility reported incident MD#00209055 revealed the following: On Friday, 8/23/2024 at approximately 7:30am Staff #4 observed Resident #18 reach for a laundry basket and Geriatric Nursing Assistant (GNA #25) allegedly open hand smacked Resident #18 on her left forearm. Further review of the initial report documented 8/23/24 at approximately 7:30 AM as the date and time when staff became aware of the incident and 8/23/24 at 11:15 AM as the date and time the initial report was submitted. The initial report was submitted almost 4 hours after facility staff observed the incident. In an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 3/26/25 at 9:04 AM, when asked what the reporting time is for allegations of abuse the DON stated within 2 hours. On 3/27/25 at 11:03 AM in an interview with the Assistant Director of Nursing (ADON) and the Extended Care Services Support Manager (ECSSM #10), the ADON stated all staff receive abuse training and reporting. During the interview, the ADON stated if an employee witnesses or suspects abuse, they have all been educated to immediately inform the ADON, DON or NHA. Additionally, the surveyor shared the facility reported investigation documents with the ADON and ECSSM #10 showing that Staff #4 observed GNA #25 smacking Resident #18 at approximately 7:30 AM and that the initial report from the facility was not submitted to the OHCQ until 11:15 AM. When asked if this incident was submitted within the required 2 hour time frame for an allegation of abuse, the ECSSM #10 stated, No. The ECSSM #10 looked at the surveyor and stated this is a teaching moment and then explained the abuse reporting process to the ADON. The surveyor shared the concern that the allegation of abuse was not reported timely (within 2 hours) and the ADON then verified and confirmed that it was not. She stated she was new to the role and will know for the next time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) The facility's investigation file related to facility reported incident MD#00215348 was reviewed by the surveyor on 3/24/2025 at 5:00 PM. Review of facility reported incident MD#00215348 revealed the following: A family member of Resident #11 reported that one evening in the middle of February, s/he came to visit his/her family member [Resident #11] and s/he observed a male caregiver, who was later identified as GNA #16, push Resident #11 away from the door and hit him/her on the upper shoulders with closed hands twice. Further review of the initial report documented 2/5/25 at 9:50 AM as the date/time staff became aware of the incident and 3/5/25 at 4:25 PM as the date/time the initial report was submitted. The initial report was submitted 6.5 hours after the facility became aware of the allegation of abuse. On 3/31/25 at 1:43 PM the DON and surveyor made a dual observation of the initial report the facility submitted to the OHCQ that documented the facility became aware of the incident on 3/5/25 at 9:50 AM and the initial report was submitted to the OHCQ on 3/5/25 at 4:25 PM. When asked if the initial report was submitted timely, the DON stated that for Resident #11, the initial report was not submitted in the required 2 hour time frame.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49304 Based on review of facility reported incidents, medical record review, and interview with facility staff, it was determined that the facility failed to thoroughly investigate 1) an allegation of abuse by failing to perform an assessment of the alleged victim, 2) an elopement, and 3) failed to follow through on appropriate corrective action to prevent further instances of medication errors. This was evident for 3 (Resident #11, Resident #16, Resident #85) of 19 residents reviewed during the recertification/complaint survey process. The findings include: 1) The facility's investigation file related to facility reported incident MD#00215348 was reviewed by the surveyor on 3/24/2025 at 5:00 PM. Review of facility reported incident MD#00215348 revealed the following: A family member of Resident #11 reported that one evening in the middle of February, s/he came to visit his/her family member [Resident #11] and s/he observed a male caregiver, who was later identified as GNA #16, push Resident #11 away from the door and hit him/her on the upper shoulders with closed hands twice. Further review of the initial report documented in the All steps taken immediately to ensure resident(s) are protected section, Resident #11 was immediately assessed, and s/he has no injuries or concerns about his/her care. On 3/26/25 at 9:04 AM in an interview with the Director of Nursing (DON) when asked what constitutes a thorough investigation, the DON stated getting a statement from the resident, witnesses, and anyone that was on the unit and trying to ascertain what happened for time, place, person, and the surrounding events. The alleged employee's caseload [assignment] is interviewed by the Social Worker or designee and the DON and SW interview the resident together and interview the employee as well. On 3/26/25 at 9:19 AM in an interview with the Nursing Home Administrator (NHA), the surveyor shared concerns that the facility's investigation files provided to the surveyor on the first day (3/24/25) of the survey did not contain evidence that the initial and final reports stated were completed and therefore, thorough investigations were not completed. For example, while reviewing MD#00215348, in the initial self-report it stated there was an assessment of the resident but there was no evidence of an assessment in the facility's investigation file. The NHA verified and confirmed the concerns stating, I got it. If it says it is in there, it should be in there. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/25 at 9:41 AM in an interview with the DON, the surveyor shared the concern that even though we were given copies of the facility's investigation files for the facility reported incidents on the first day of the survey, more documents keep being presented to the survey team, but only upon request. For example, the DON verified and confirmed the concerns stating, the NHA and he talked about it. During the interview, the DON was asked to share what he remembered about the incident with GNA #16 and Resident #11. He stated he remembered the day it was reported. Staff #4 got the concern [from Resident #11's family member] when she was treating another resident: that the week his/her family member was admitted s/he was concerned coming in the door that a guy with red shoes who did not speak very good English was at the door and she did not appreciate his approach because he struck Resident #11 in the back repeatedly. The DON also stated that Resident #11 was checked, and he still had full range of motion of his upper body, but this was almost 2 weeks after the alleged incident. When asked if the facility would still complete an assessment on the resident he stated, Yes. The surveyor requested a copy of the assessment. On 3/31/25 at 10:48 AM review of Resident #11's medical record did not reveal any assessment of the resident, nor any progress notes related to the incident in the medical record during the time of the investigation (3/5/25 - 3/10/25). In an interview with the DON on 3/31/25 at 10:49 AM, he verified and confirmed there was no assessment completed (as the facility had documented on their initial self-report) of Resident #11 in the resident's medical record. 43096 2) During a portion of investigating self-reported elopement incidents on 3/25/25, it was revealed that Resident #16 eloped from the Heath care (nursing home) building on 12/02/23. The review of the facility's investigation records revealed: The first incident, MD00200549, occurred on 12/02/2023: the resident left the secure area of the Health care building and ambulated the assisted living building lobby. The resident had a WanderGuard bracelet when the incident happened. However, it failed to activate the Health Care door alarms, and he/she exited without a witness. During an interview with the Director of Nursing (DON) on 3/25/25 at 9:20 AM, he said Resident #16's WanderGuard alarm was not activated on 12/02/23. However, there was no documentation to support how the facility investigated the root cause and how and/or why it was not functioning, nor was there a further audit of other residents' WanderGuard. Additionally, a review of the facility's education documentation dated 12/05/23 about 'elopement in-service' listed eight staff members' names and signatures. On 3/31/25 at 8:54 AM, during an interview with the DON, the surveyor asked who was required to receive education regarding the above elopement incident. He stated it was supposed to be all staff. The DON confirmed that the facility had approximately 30 nursing staff, including Nurses and aides. He verified that not all staff received education at that time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) During a review of the facility self-reported incident, MD00212528, on 3/26/25 at 10:36 AM, it was revealed that the facility reported on 12/07/2024 that 15ml of liquid lorazepam (a medication used to treat anxiety disorders. Considered as controlled medications which are drugs that have the potential for abuse and addiction and are therefore regulated by the government) for Resident #85 was not counted by Licensed Practical Nurse (LPN #11) and Registered Nurse (RN #27). Also, RN #26 failed to report the discrepancy in counting controlled medication in a timely manner. Further review of the facility's investigation revealed that on 12/07/24 dayshift LPN #11 was precepting RN#14. RN #14 performed counting controlled medication with RN #27 without LPN #11: RN #14 and RN #27 did not count liquid controlled medication, which was located in the medication refrigerator in the medication room. On 12/07/25, at the beginning of the evening shift, RN #27 and RN #26 counted the liquid lorazepam in the medication room refrigerator; they noted a discrepancy of amount 15ml: the controlled substance care reflected 30ml, and there was only 15ml noted in the vial. Instead of reporting the discrepancy to the DON, RN #26 contacted LPN #11 via phone to verify whether there was a missing Lorazepam dose. On 12/07/24, oncoming night shift RN #28 counted the controlled substances; it was noted that there was a discrepancy, and she reported it to the DON. During an interview with DON on 3/27/25 at 7:40 AM, the surveyor asked what the facility did to prevent similar incidents. He stated that the facility offered education to nursing staff and performed audits. The surveyor requested their education record and audit form. On 3/27/25 at 3:40 PM, the review of the in-service training sheet revealed 10 nurses listed and signed. There was no signature for LPN #14, who did not count the liquid controlled medication. The DON verified that not all nurses received the education. Also, he stated that he verified the amount of liquid controlled medication on 12/07/24, not thoroughly auditing. He said, I did not have audit form. The surveyor shared concerns about the absence of action from the facility to prevent similar incidents. The DON validated it.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43096 Based on interviews with facility staff and review of resident medical records and the facility incident report, it was determined that facility nursing staff failed to follow professional standards of nursing practice when performing controlled medication counts. This practice was noted for one (Resident #84) of two residents reviewed for controlled medication administration and one self-reported incident, MD00212528, reviewed during this recertification/complaint survey. The findings include: Controlled medications are drugs that have the potential for abuse and addiction and are, therefore, regulated by the government. They are classified into five schedules (I to V) based on their medical use, potential for abuse, and risk of dependence. As a result, it is a standard of nursing practice to administer narcotic medication only from sources that can be both accounted for and reconciled. This practice discourages the diversion of abusable medication and ensures that narcotic medication is tracked according to federally mandated standards. a) During a review of the facility self-reported incident, MD00212528, on 3/26/25 at 10:36 AM, it was revealed that the facility reported on 12/07/2024 that 15ml of liquid lorazepam (a medication used to treat anxiety disorders. Considered as controlled medications which are drugs that have the potential for abuse and addiction and are therefore regulated by the government) for Resident #85 was not counted by Licensed Practical Nurse (LPN #11) and Registered Nurse (RN #27). Also, RN #26 failed to report the discrepancy in the controlled medication timely. Further review of the facility's investigation revealed that on 12/07/24, dayshift LPN #11 was precepting RN#14. RN #14 performed counting controlled medication with RN #27 without preceptor: RN #14 and RN #27 did not count liquid controlled medication, which was located in the medication refrigerator in the medication room. On 12/07/25, at the beginning of the evening shift, RN #27 and RN #26 counted the liquid lorazepam in the medication room refrigerator; they noted a discrepancy of amount 15ml: the controlled substance care reflected 30ml, and there was only 15ml noted in the vial. Instead of reporting the discrepancy to the DON, RN #26 contacted LPN #11 via phone to verify whether there was a missing Lorazepam dose. On 12/07/24, oncoming night shift RN #28 counted the controlled substances; it was noted that there was a discrepancy, and she reported it to the DON. During an interview with DON on 3/26/25 at 10:47 AM, he stated that two nurses (oncoming duty and off duty) must verify all the controlled medication counts, enter the numbers on the medication cards, check the refrigerator, and sign. The DON acknowledged the above incident, which resulted from the facility's nurses not following professional standards while they counted controlled medications. b) On 3/26/25 at 10:50 AM, the surveyor reviewed the facility's shift change controlled medication accountability signature sheet for counting controlled medication at each shift change. The form had columns for date, shift, nurses' signatures for off-duty and on-duty, number of items added and delivered during shift, number of items removed during shift, and total number of items. The review revealed the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The sheet for cart 1 was documented from 3/08/25 to 3/23/25: no nurses' signature on 3/13/25 evening on-duty, and night off-duty, and no on- duty's signature on 3/20/25 day shift. A total number of items was blank on the 3/10/25 day and night shift, 3/12/25 evening shift, 3/16/25 night shift, 3/18/25 evening and night shift, 3/19/25 evening and night shift, 3/20/25 evening shift, and 3/21/25 evening shift. - The sheet for cart 2 was documented from 3/08/25 to 3/23/25: no nurses' signature on the 3/11/25 day shift on-duty and evening shift off-duty, the 3/12/25 day shift on-duty and evening shift off-duty, and the 3/22/25 evening shift off-duty. The total number of items was blank on the 3/08/25 evening and night shift, the 3/12/25 evening and night shift, the 3/13/25 night shift, the 3/16/25 day shift, the 3/18/25 night shift, the 3/19/25 night shift, and the 3/20/25 evening and night shift. During an interview with the Director of Nursing (DON) on 3/26/25 at 10:47 AM, he stated that two nurses (on-duty and off-duty) were required to verify controlled medication by counting, and they needed to fill out the shift change controlled medication accountability signature sheet with numbers with signatures. The surveyor reviewed sheets for cart 1 and cart 2 with the DON. He validated the above concerns.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43096 Based on review of medical records and other pertinent documentation, interview with facility staff, and observations, it was determined that the facility failed to have an effective system in place to prevent residents with cognitive impairments from leaving the facility without appropriate supervision. This failure led to 1) Resident #16, who was known to have exit-seeking/elopement behaviors with previous two elopement incidents, found outside of the building on 12/13/24 around 6 PM, and 2) Resident #20, who had a wanderguard placed due to high risk of elopement since May 2024, found in the Assisted Living (AL) library on 3/20/25 around 9 AM. This was evident for 2 of 5 reported elopement incidents reviewed during this annual survey. The above findings for Residents #16 and #20 were identified as Immediate Jeopardy on 3/25/25 at 7:45 PM. The facility submitted a plan for removal on 3/25/25 at 10:04 PM, which was rejected. The facility submitted a subsequent revised plan of action at 11:06 PM on 3/25/25, which was reviewed by the surveyor and the Office of Health Care Quality, and accepted to remove the immediacy at 3/25/25 at 11:30 PM. The Immediate Jeopardy was abated on 3/25/25. The surveyor team verified compliance with the plan on 3/31/25 at 10:00 AM. The findings include: A WanderGuard is a wander management system designed to protect memory care residents from elopement. It uses bracelets, sensors, and a technology platform to alert caregivers and automatically lock doors when a resident approaches a monitored area. BIMS (Brief Interview for Mental Status) is a standardized assessment tool used to screen the cognitive functioning of residents in long-term care facilities. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. 1) During a review of the facility reported incident, MD00212713, on 3/25/25 around 8 AM, it was revealed that Resident #16 eloped from the nursing home building after dinner on 12/13/24 at 6:07 PM, was observed outside by an employee, and immediately escorted into the Main building. The surveyor noted that the facility's investigation packet contained written statements of staff dated 12/02/23. In an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 3/25/25 at 9:20 AM, the DON confirmed that he mixed the documentation for two different incidents (December 2023 and December 2024) in one file. During the interview he verified that Resident #16 had exit-seeking behaviors and elopement incidents reported to the Office of Health Care Quality three times since his/her admission: 12/02/2023, 7/28/2024, and 12/13/2024. Also, the DON said, That was one reason why Resident #16 was moved to the nursing home side of the facility where there's more staff. The resident is very mobile and moves quickly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/25/25 at 11:10 AM, a review of the facility's elopement evaluation revealed that the most recent evaluation prior to the elopement episode was on 10/29/24: the resident scored 30; and the evaluation noted , '10 or more = at risk for elopement'. However, no evaluation was completed after the elopement incident on 12/13/24. In an interview with the DON and Assistant Director of Nursing (ADON) on 3/25/25 at 11:56 AM, they stated that the purpose of the evaluation was only to determine whether they needed a WanderGuard. So, it was not required to evaluate them after each episode. On 3/25/25 at 9:40 AM, review of Resident #16's medical records revealed that the resident had two WanderGuards (wrist and ankle) since the first elopement episode occurred on 12/02/2023. Additionally, the review showed that the resident's BIMS score was zero (0) to three (3), indicating severe cognitive impairment, upon his/her admission in October 2023. On 3/25/25 at 9:50 AM, a review of the facility's investigation documentation revealed that on 12/13/24, Resident #16 left the Healthcare Center (HCC, the facility's nursing home building) dining room after eating his/her dinner around 6:10 PM. An employee (Driver #8) found the resident at approximately 6:20 PM outside close to the facility van near the Manor House entry located near the front of the facility. The resident was escorted back into the facility. However, the review of the WanderGuard alarm details report for Resident #16 showed no record of when the resident eloped the building. Only one incident was recorded on 12/13/25 at 6:13 PM at the door connecting the AL and HCC buildings. During an interview with the DON on 3/25/25 at 3:30 PM, he confirmed that no alarm went off when the resident eloped on 12/13/24, and the alarm only recorded when the staff escorted the resident back through to the HCC building at 6:13 PM. On 3/25/25 around 4 PM, the surveyor made observations outside of the HCC building's Main Entrance and of the various roads, including the road where facility staff found Resident #16 on 12/13/24. Upon exiting the HCC's Main Entrance, there is a road (Valley View) to the left lined with parking along the left-hand side of the road. It is traveled to access Independent Living housing by residents, visitors, et cetera. The road to the sharp right of the HCC's Main Entrance leads to the loading dock where all deliveries are made and vehicles may be exiting or entering at any time of day. Upon exiting the HCC's Main Entrance, the road straight ahead leads to the traffic circle with facility vans and parking on both sides of the road with hazards such as cement, wheel stops for the parking spaces, sidewalks, and curbs. Residents, visitors, and vendors of the facility frequently access these three roads. On 3/25/25, between 6:00 PM and 6:40 PM, the surveyor observed a facility van and five cars driving on the road directly outside the HCC's (Nursing home) Main Entrance towards the Manor House (Assisted Living) building, where Resident #16 was found on 12/13/24. 2) On 3/25/25 at 5:20 PM, review of Resident #20's BIMS revealed that s/he scored four (4) to ten (ten) upon admission in April 2023. The most recent assessment on 12/31/24, the resident scored 4 out of 15 indicating severely impaired cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215278	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Meadows Retirement Com.	11630 Glen Arm Road Glen Arm, MD 21057

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #20's medical record on 3/25/25 at 9:30 AM revealed he/she was at high risk of wandering based on evaluation on 3/31/24, and had a previous elopement episode on 5/29/24, according to the review of facility-reported incident MD00206159. After this elopement incident on 5/29/24 where the resident left the HCC building, the resident was assessed and a WanderGuard bracelet was placed. A review of the facility self-reported incident, MD00215933, on 3/25/25 around 9 AM, revealed that Resident #20 was found in the Assisted living library (located in a connected hall between the HCC and AL buildings) on 3/20/25 at 9:28 AM. On 3/25/25 at 5:14 PM, a review of Resident #20's progress note written by Licensed Practical Nurse (LPN #2) revealed that on 3/20/25 at 9:26 AM other nurse on duty reported to this writer that resident was in the library. Other nurse on duty stated social worker found him/her. About 10 mins later other nurse reported someone outside of nursing department called management. Head to toe assessment completed, no injury noted. Resident denies any pain or discomfort, when asked what had happened, he/she stated I don't know. Resident placed near the door, a WanderGuard to the right ankle triggered an alarm. Pager read that the resident was near the door at 9:26 AM. Physical Therapist stated that was the time she was transferred back to the HCC. On 3/25/25 at 12:12 PM, during a dual observation of the facility doors with the Maintenance Director (Staff #7), the surveyor observed that the HCC building has a locked door that connects to the AL library, with a WanderGuard alarm installed on it. However, review of the WanderGuard alarm record showed that no alarm went off on 3/20/25 when Resident #20 reached that door, allowing the resident to pass through. The WanderGuard alarm was only detected on the report at 9:15 AM on 3/20/25 when Resident #20 was escorted back to the HCC building and passed back through that door with facility staff. On 3/25/25 at 8:55 PM in an interview with the DON and NHA stated there was a time stamp for 9:15 AM on the WanderGuard alarm report. During the interview they stated Resident #20 was seen on the HCC unit at 9 AM and was being escorted back to the unit by 9:15 AM. The alarm only went off when s/he came back through the door. The NHA and DON confirmed that they do not know how Resident #20 was able to get through the door without it alarming. During continued interviews with the DON and NHA on 3/25/25 at 10:03 PM, the surveyor asked when did a WanderGuard alarm go off, the NHA stated anytime residents who had WanderGuard bracelets get close to a WanderGuard box. There are a total of 5 on doors throughout the building, it will alarm. During the interview, when asked when an entry will be captured on the WanderGuard alarm report, the NHA stated when a resident gets too close to the door and it sets off the alarm. The dual observation and interview with the Maintenance Director (Staff #7) on 3/25/25 at 12:20 PM revealed that: - The main entrance door for the HCC can be opened by pushing for 30 seconds while the WanderGuard alarm is on. A visitor or anyone on the other side of the door who is entering the facility can also open the door by pushing the 'bypass' button below the outside door handle while the WanderGuard alarm is on. (continued on next page)

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	215278	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Meadows Retirement Com.	11630 Glen Arm Road Glen Arm, MD 21057

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The computer for the WanderGuard alarm's sound is very faint and has no visual alerting signals. Additionally, the computer is set off to the side and not located where staff was observed sitting while at the nurse's station during the duration of the survey. - The door connecting the HCC to the AL library has a sign that says push until alarm sounds, door can be opened in 30 seconds. Staff #7 said, This door used to open when you pushed on it for 30 seconds, but now it does not. The life safety code did not allow us to remove the sign. During the observation near the main entrance door for HCC and interview with Staff #7 on 3/25/25 at 12:25 PM, the surveyor asked him if he was down the hallway and the computer alarm sounded if he thought he'd hear it. He stated, No. In an interview with the Nursing Home Administrator (NHA) on 3/25/25 at 12:30 PM, when asked if he would be able to hear the computer alarm sound for the wanderguard if he were down the hallway or in a resident's room, he stated, No, I probably wouldn't hear that computer alarm if I was down the hallway, but the alert is also sent to the GNA's (Geriatric Nursing Aide) pager. The ADON stated that there are three pagers for GNAs and that nurses have phones. When asked if the phones are connected to the wanderguard system, the ADON replied, No. On 3/25/25 at 7:45 PM an Immediate Jeopardy was called related to the facility's failure to have an effective system in place to prevent residents with cognitive impairments from leaving the facility without appropriate supervision. The facility's plan of correction was submitted to the State Agency at 10:04 PM on 3/25/25 and the plan was accepted at 11:30 PM. The Immediate Jeopardy Abatement Plan included: - Immediately on 3/25/25, the front entrance doors at nursing desk and the door exiting the healthcare center level of living and entering assisted level of living will have a team member present monitoring 24 hours a day, 7 days a week to ensure constant visual monitoring of individuals exiting the community until a mechanism is installed to create immediate notification to community staff for unauthorized exits. - The mechanism is installed as soon as possible but no later than one month. - On 3/25/25, the facility consulted [name of security company] to explore solutions to increase door security related to unauthorized exits. A senior technician plans to come on 3/26/25. - On 3/25/25, current community staff of all disciplines were educated, and additionally, community staff will be educated on this immediate process change noted related to door security. - Audit will be completed daily by NHA or designee on the front entry door monitoring and door between assisted living and nursing home. - Audit results will be submitted for review and recommendation to the Quality Assurance Performance Improvement Committee.