STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215329	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrooke CT Skilled Care Buckingham's Choice	3200 Baker Circle Adamstown, MD 21710

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined that facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 8 (#21, #1, #19, #7, #22, #5, #16, #30) of 19 residents reviewed during the recertification/complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 2/12/26 at 12:45 PM a review of Resident #21's medical record was conducted. Review of Resident #21's January 2026 Medication Administration Record (MAR) revealed Resident #21 received Metformin every morning and evening for diabetes and Gabapentin 3 times per day. Gabapentin is classified as an anticonvulsant drug and is commonly used to treat nerve pain as well as partial seizures. Metformin is a medication that primarily is used as a first-line treatment for type 2 diabetes. Review of Resident #21's MDS assessment with an assessment reference date (ARD) of 1/26/26, Section N0415 (High-Risk Drug Classes), failed to capture the hypoglycemic (Metformin) and anticonvulsant (Gabapentin). On 2/17/26 at 12:45 PM Staff #3, MDS coordinator was interviewed and stated that he was not aware that Gabapentin was an anticonvulsant. He confirmed the errors. 2) On 2/17/26 at 10:12 AM a review of Resident #1's medical record was conducted and revealed an October 2025 MAR that documented Resident #1 received the medication Gabapentin for polyneuropathy three times per day. Continued review of the October 2025 MAR documented that Resident #1 also received the Abrysvo (RSV) vaccine via injection on 10/22/25. Respiratory syncytial virus (RSV) causes infections of the lungs and respiratory tract. Review of Resident #1's MDS assessment with an ARD of 10/24/25, Section N0415, failed to capture Gabapentin as an anticonvulsant and failed to capture the injection in section N0300 (injections). Review of Resident #1's MDS assessment with an ARD of 1/22/26 also failed to capture Gabapentin in Section N0415. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/17/26 at 12:45 PM Staff #3, MDS coordinator confirmed the errors. 3a) On 2/17/26 at 10:41 AM a review of Resident #19's medical record was conducted and revealed an October 2025 MAR that documented Resident #19 received Aspirin 81 mg. every day and received Naproxen (NSAID) on 10/21/25 at 10:05 AM for pain. Aspirin is primarily classified as a nonsteroidal anti-inflammatory drug (NSAID) and an anti-platelet agent. Additionally, Resident #19 received the injection, Abrysvo (RSV) vaccine on 10/22/25. Review of Resident #19's MDS with an ARD of 10/22/25, Section N0415 failed to capture the anti-platelet Aspirin and the injection in Section N0300. Review of Section J0100, Pain Management, B. received PRN (when needed) pain medications, was coded, 0. The facility failed to capture the Naproxen that was given on 10/21/25 at 10:05 AM for a pain level of 5 on a 1 to 10 scale. b) Review of Resident #19's January 2026 MAR documented that Resident #19 received Aspirin every day, Naproxen on 1/14/26 at 22:01 (10:01 PM) and Tylenol on 1/15/26 at 8:51 PM. Review of Resident #19's MDS with an ARD of 1/20/26, Section N, failed to capture the use of the antiplatelet drug Aspirin. Additionally, Section J0100, failed to capture the PRN use of Tylenol and Naproxen. On 2/17/26 the MDS Coordinator confirmed the findings. 4) On 2/17/26 at 12:54 PM a review of Resident #7's medical record was conducted and revealed a November 2025 MAR that documented Resident #7 received the medication Gabapentin (anticonvulsant) and Metformin every day. Review of Resident #7's MDS with an ARD of 11/10/25, Section N0415, failed to capture the anticonvulsant and hypoglycemic medications. On 2/17/26 at 12:45 PM Staff #3 confirmed the findings. 5) On 2/17/26 at 12:57 PM a review of Resident #22's medical record was conducted. Review of Resident #22's November 2025 MAR documented that the Prevnar vaccine (injection) was administered on 11/10/25. Review of Resident #22's admission MDS with an ARD of 11/14/25, Section N0300, Injections, documented the resident did not receive any injections. The facility failed to capture the injection. On 2/17/26 at 12:50 PM the MDS coordinator confirmed the findings. On 2/17/26 at 1:00 PM the DON was informed of the MDS concerns. 6) Review of Resident #5's medical record on 2/13/26 revealed the Resident had a fall on 8/12/25 with injury. Review of Resident #5's Quarterly MDS dated [DATE] Section J Health Conditions revealed Section J1800 titled Any falls since admission/entry or reentry or prior assessment is coded no. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the MDS Coordinator on 2/13/26 at 9:42 AM confirmed Resident #5 should have been coded yes in Section J1800 for the 8/12/25 fall on the 8/25/25 Quarterly MDS Assessment. 7) Review of Resident #16's medical record on 2/13/26 revealed the Resident had a fall on 8/4/25 and 8/5/25. Review of Resident #16's Annual MDS dated [DATE] Section J Health Conditions revealed Section J1900 Number of falls since admission/entry or reentry or prior assessment is coded one. Interview with the MDS Coordinator on 2/13/26 at 9:42 AM confirmed Resident #16 should have been coded for two falls in Section J1900 8/28/25 Quarterly MDS Assessment. 8) Review of Resident #30's medical record on 2/13/26 revealed the Resident was admitted to hospice on 1/12/26. Review of Resident #30's Significant Change MDS dated [DATE] Section O Special Treatments, Procedures and Programs K1 Hospice Care revealed the Resident was coded no. Interview with the MDS Coordinator on 2/13/26 at 9:00 AM confirmed Resident #30 should have been coded yes in Section O K1 Hospice Services on the 1/22/26 Significant Change MDS.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility staff failed to ensure that the attending physician visit residents at the required intervals . This was evident for 3 (Resident #14, #16, #9) of 19 residents reviewed during an recertification/complaint survey.The findings include: 1) Review of Resident #14's medical record on 2/13/26 revealed the Resident was admitted to the facility on [DATE]. Review of Resident #14's physician notes for the first 90 days revealed the Resident was seen by the physician on 7/18 and 8/22/25. There are no physician notes for September 2025. The next physician note for Resident #14 is on 10/23/25. Interview with the Director of Nursing on 2/13/26 at 9:31 AM confirmed Resident #14 was not seen by the physician every 30 days for the first 90 days since admission on [DATE]. 2) Review of Resident #16's medical record on 2/13/26 revealed the Resident was admitted to the facility in 2022. Review of Resident #16's physician notes in 2025 revealed the Resident was seen by the physician on 4/24/25 and then not again until 9/25/25, Interview with the Director of Nursing on 2/13/26 at 9:33 AM confirmed Resident #16 was not seen by the physician every 60 days in 2025. 3) On 2/12/26 at 1:45 PM a review of Resident #9's medical record revealed Resident #9 was admitted to the facility in August 2021. Review of the documentation section of Resident #9's medical record revealed physician notes that were uploaded into the system. The physician's notes that were uploaded were dated 1/20/25. There were no other physician's notes in Resident #9's medical record until the 9/15/25 physician's visit. There were no physician visits in the paper medical record. After 9/15/25 there were no other physician's visits until 12/18/25. On 2/12/26 at 1:42 PM an interview was conducted with the DON regarding the physician visits. The DON stated that it was unusual that there were no notes in the system and that the 2 staff members that uploaded the physician's notes switched doing the task. On 2/12/26 at 2:14 PM the DON stated that the only other physician's note she found was dated 2/17/25 that she had the physician's office send over. The DON stated that another facility had a data breach and maybe the physician was using another way to document. On 2/17/26 at 1:00 PM the issue was reviewed again with the DON. The DON stated she did not have any answers and that she had already started working on a plan of correction and talked with the physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, medical record review, and interview, it was determined the facility failed to provide respiratory services in accordance with professional standards of practice. This was evident for 1 (Resident #9) of 2 residents reviewed for respiratory care during the recertification/complaint survey.The findings include: On 2/11/26 at 9:09 AM observation was made of Resident #9 sitting in his/her room. Resident #9 was receiving 3.5 L (liters) of oxygen via nasal cannula. On 2/12/26 at 9:09 AM a second observation was made of Resident #9 receiving oxygen at 3.5 L per nasal cannula. On 2/12/26 at 11:16 AM Resident #9's medical record was reviewed and revealed Resident #9 had diagnoses that included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, atrial fibrillation, acute diastolic (congestive) heart failure, aphasia, and late onset Alzheimer's Disease. Review of February 2026 physician's orders revealed that the resident was to have oxygen administered at 2 liters per minute. Review of a 1/19/26 physician's note documented that Resident #9 had, chronic respiratory failure, oxygen after COVID in 2020, intermittent upper airway wheezing not responsive to steroids. Review of Resident #9's care plan, have an altered cardiovascular status r/t CHF (congestive heart failure), hypertension, Afib had the intervention, I may need to use oxygen. Follow settings per physician order. The care plan was created on 7/20/23. A second care plan, have altered respiratory status and utilize oxygen due to shortness of breath r/t COPD (chronic obstructive pulmonary disease) had the intervention, administer my medication/inhalers as ordered. Review of Resident #9's February 2026 Treatment Administration Record (TAR) documented that every shift the nurses were signing off that Resident #9 was receiving oxygen at 2 liters per minute, not 3.5 liters per minute. On 2/12/26 at 11:22 AM LPN #6 was asked to come to Resident #9's room with the surveyor. LPN #6 was asked how many liters of oxygen Resident #9 was supposed to be receiving. LPN #6 stated, 2 liters. LPN #6 looked at the oxygen concentrator and confirmed that Resident #9 was receiving 3.5 liters. On 2/17/26 at 1:00 PM the surveyor went over with the Director of Nursing (DON) that Resident #9 was not receiving the correct amount of oxygen and that the nurses were signing off that the resident was receiving 2 liters. The DON stated that she was aware of the issue and did not think the oxygen concentrator was working properly so they switched it out and got the resident another one.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 2 (Resident #5 and #6) of 19 residents reviewed during a recertification/complaint survey.The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) Review of Resident #5's medical record on 2/12/26 revealed the Resident was admitted to hospice services in September 2025. Further review of Resident #5's medical record on 2/13/26 with the Director of Nursing (DON) revealed there are no hospice notes in the Resident's medical record after 10/22/25 from the hospice nurse or hospice GNA (geriatric nursing assistant). Interview with the DON on 2/13/26 at 10:26 AM confirmed there are no hospice notes in Resident #5's medical record after 10/22/25. On 2/13/26 at 11:15 AM the DON brought the nurses' hospice notes from the following dates: 10/31/25, 11/07/25, 11/10/25, 11/14/25, 11/19/25, 11/21/25, 11/24/25, 12/11/25, 12/15/25, 12/24/25, 12/31/25, 1/5/26, 1/8/26, 1/12/26, 1/19/26, 1/26/26, 2/2/26 and 2/9/26 to the Surveyor after the DON stated she obtained the notes from the Hospice Nurse. During interview with the Hospice Nurse on 2/17/26 at 10:14 AM, the Hospice Nurse stated she comes and sees the Resident once or twice a week usually and the Hospice GNA sees the Resident twice a week. The Hospice Nurse stated she does have good communication with the facility staff but will now make sure the hospice notes are in the Resident's medical record. 2) During interview with Resident #6 on 2/11/26 at 9:45 AM, Resident #6 stated that he/she has a left top tooth that is broken. Resident #6 stated he/she is not in any pain. Resident #6 stated he/she was seen by someone in the facility and also a dentist outside the facility for his/her teeth but unsure what is next. Review of Resident #6's medical record on 2/13/26 revealed the Resident was admitted to the facility in 2023 and there were no dental visit notes documented in 2025 or 2026. The Director of Nursing (DON) was made aware on 2/13/26 at 10:30 AM the Surveyor could not find any dental visit notes and the Resident was complaining of a broken upper left tooth. The DON stated he/she was not aware of the Resident stating his/her tooth is broken. On 2/13/26 at 11:15 AM, the DON stated they do not have any notes from the dental visits and the Resident's spouse is the one that takes the Resident to his/her dental visits. The Surveyor advised the DON the Resident stated he/she was also seen by someone in the facility. On 2/17/26 at 8:10 AM the DON provided the Surveyor with notes from a dental visit on 6/20/25 at the facility and from an outside dental visit in November 2025. The DON stated she had contacted both dental providers and was able to obtain the dental provider's notes. The DON confirmed the dental provider notes were not in the Resident's medical record on 2/13/26. The DON also stated she has followed up with Resident #6's spouse regarding future dental treatment.