STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwest Healthcare Center	4601 Pall Mall Road Baltimore, MD 21215

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on review of facility reported incident #3013380, medical record review, and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 3 (#4, #17, #18) of 18 residents reviewed during a 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 6/16/26 at 12:38 PM a review of facility reported incident #3013380 was conducted along with Resident #4's medical record.Review of a 5/12/26 at 04:51 change in condition note documented that while assisting the resident in the bathroom, the resident became unsteady on his/her feet and fell. There was a small amount of bleeding observed from the nose and mouth.Review of a 5/12/26 at 12:43 alert note documented the physician and nurse practitioner were made aware of the fall and there was a new order to apply ice pack every shift for swelling.Review of a 5/12/26 at 23:59 progress note from the physician documented, nose swelling and mild erythema around lateral nostrils. The note also documented a mild bruise like area on top of the nose.Review of a 5/13/26 at 16:30 nurse's note documented, transferred to ER (emergency room) for fall on face with nose bleed and bruising around eyes, rule out head and facial trauma.Review of a 5/13/26 at 23:59 physician's progress note documented, some new bruising around the medial areas of eyes bilaterally.Review of Resident #4's Discharge Return Anticipated MDS with an assessment reference date (ARD) of 5/13/26: Section J, falls, J1900B, number of falls since admission/entry or reentry or prior assessment, documented 1 fall with no injury. This was incorrect as the resident had bruising after the fall.On 6/17/26 at 10:27 AM an interview was conducted with MDS Coordinator #16 who stated, it was not a major injury, and I will have to check with my regional to see if it should be coded.On 6/17/26 at 11:30 AM MDS Coordinator #16 confirmed the MDS error.2) On 6/17/26 at 9:00 AM a review of Resident #17's medical record was conducted.Review of a 5/14/26 at 14:58 alert charting observation note documented that the resident was noted with swelling on the forehead. During the investigation Resident #17 stated he/she fell down from his/her wheelchair 2 days ago in the downstairs bathroom. Resident #17 complained of a mild headache and the nurse practitioner ordered to send the resident out to the emergency room via 911 for a CT scan of the head.Review of a 5/15/26 at 20:53 nurse's note documented that Resident #17 was noted with a swelling/bump on the forehead due to a fall that happened 2 days prior per oral statement from the resident and staff (ADON) Assistant Director of Nursing.Review of Resident #17's quarterly MDS with an ARD of 5/29/26 documented no in Section J1800, any falls since admission/entry or reentry or prior assessment (which was 3/14/26). This was inaccurate as the resident was noted to have a fall according to the nursing notes. The status of the quarterly MDS was export ready which indicated that the MDS was completed and locked and waiting to be transmitted.On 6/17/26 at 11:30 AM an interview was conducted with the MDS Coordinator #16 who confirmed the MDS error.3) On 6/17/26 at 9:20 AM a review of Resident #18's medical record was conducted. Review of a 5/25/26 at 01:00 (continued on next page)

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 - Few	telehealth encounter note documented that Resident #18 had an unwitnessed fall and reported that he/she was in and out of consciousness with fluctuating blood pressures.Review of a 5/25/26 at 9:25 AM change in condition note documented that Resident #18 was found on the floor beside the wheelchair. It was documented that the resident complained of dizziness before falling.Review of Resident #18's 5/25/26 Discharge Return Anticipated MDS Assessment, Section J1800, any falls since admission/entry or reentry or prior assessment was coded no. The facility failed to capture the fall.On 6/17/26 at 11:30 AM an interview was conducted with the MDS Coordinator #16 who confirmed the MDS error.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on complaint, medical record review, and interview, it was determined that the facility failed to have a care plan meeting after an MDS assessment. This was evident for 1 (Resident #6) out of 18 residents reviewed during a complaint survey.The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 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. On 6/15/26 at 8:15 AM a review of complaint 2785504 along with Resident #6's medical record was conducted. Review of a 1/23/26 at 15:35 care conference note documented that a care plan meeting was held on 1/21/26. Further review of Resident #6's medical record revealed the last MDS assessment was on 4/23/26. There was no care plan meeting after the last MDS assessment. There have been no care plan meetings since 1/23/26. On 6/15/26 at 10:41 AM an interview was conducted with the Social Work Director #7 who stated that care plans are generally done quarterly after the MDS assessment, but new admissions are usually after the week they are admitted to the facility. Social Work Director #7 confirmed that Resident #6's care plan meeting that was supposed to happen after the 4/23/26 MDS assessment was missed.