STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215372	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenwald	800 Southerly Road Towson, MD 21286

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review and interview with staff, it was determined that the facility failed to ensure the residents' medication regimen was free from unnecessary medication by increasing psychotropic medication dose without documentation in the record explaining the reason for an increased dose. This was evident for one (Resident # 29) of five residents selected for unnecessary medication regimen review during this recertification/complaint survey. The findings include: Psychotropic medications are drugs that influence brain activity related to mental processes and behavior. They are commonly used to treat conditions like depression, anxiety, psychosis, and bipolar disorder by altering the brain's chemical balance, thereby impacting mood, thinking, and behavior. During a review of Resident #29's medication regimen on 6/20/25, at 12:09 PM, it was revealed that the resident was prescribed Lorazepam (Ativan), which is used to treat anxiety disorders. A further review of the Lorazepam order history indicated the following: - Lorazepam 0.25 ml via sublingual route, twice daily (6 AM and 2 PM) for 14 days for anxiety: Started on 6/10/25, and discontinued on 6/13/25. - Lorazepam 0.25 ml via sublingual route, three times daily (6 AM, 2 PM, and 10 PM) for anxiety: Started on 6/13/25. - On 6/18/25, the Lorazepam sublingual order for anxiety was revised to 0.25 ml twice daily (6 AM and 2 PM), and the bedtime (HS) dose was increased from 0.25 ml to 0.5 ml. - Lorazepam 0.25 ml via sublingual route every 4 hours as needed for anxiety: Started on 6/06/25, and remains an active order. On 6/20/25, at 1:00 PM, the surveyor reviewed Resident #29's medical records for a Psychology evaluation. The review revealed that a CRNP-PMH (Certified Registered Nurse Practitioner in Psychiatric Mental Health) saw the resident on 6/10/25, suggesting a schedule for Lorazepam to manage anxiety/agitation. However, no further psychiatric evaluation documentation was found. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #29's progress notes revealed a nursing staff entry on 6/12/25, at 3:46 PM, documented as a late entry for 6/10. The note stated: [Attending physician's name] notified of psych CRNP recommendation to consider Lorazepam 0.25 ml solution three times a day (TID), but MD opted to have twice a day (BID) instead for now at 9 AM & 2 PM. Patient's daughter aware and in agreement. However, no additional documentation regarding the increase in dosage was recorded in the resident's medical records. During an interview with the Director of Nursing (DON) on 6/20/25, at 2:23 PM, she stated that Resident #29 was enrolled in hospice care on 6/06/25. She added, The Psychologist does not see hospice residents, but they evaluated this resident on 6/10/25 and recommended Lorazepam. On 6/10/25, the attending physician ordered Lorazepam twice a day. On 6/13/25, the Nurse Practitioner revised the order as three times a day, then the attending physician increased the bedtime dose. The surveyor requested any provider documentation regarding the increasing psychotropic medication. On 6/20/25, at 3:16 PM, the DON provided copies of provider visit notes dated 6/10/25, and 6/13/25. However, no further evaluation was documented regarding the psychotropic dose increase on 6/18/25. The surveyor informed the DON of this concern, which she validated.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on a review of facility investigative material, medical records, and interviews with facility staff, it was determined that the facility failed to thoroughly investigate an injury of unknown origin for a resident. This was evidenced by 1 (Resident #140) of two residents reviewed for injury of unknown origin during this recertification/complaint survey. The findings include: During an investigation of the facility's internal investigation for MD00189789, on 06/16/2025 at 12:31 PM, it was revealed that on 03/05/2023, a night shift (11 PM - 7 AM) Geriatric Nurse Aide (GNA) reported a reddened area on Resident #140's right side of the face. A review of Resident #140's medical records on 06/17/2025 at 8:05 AM, revealed a progress note written by nursing staff on 03/05/2023 at 7:41 AM stated, Resident was reported by caregiver to have some discoloration to his/her face. Resident noted to have some rash-like redness to the right half side of the face, resident has some blood on his/her ear. Resident also noted to have some purple discoloration to the corner of his/her right eye. Resident had a sitter with him/her in the room all night. No report of changes given, and the sitter did not report any changes to patient. AM nurse notified. Message sent to MD/RP. Further review of Resident #140's medical records revealed that the resident did not have a fall incident and/or change in condition prior to the discoloration noted on 03/05/2023. A review of the facility's investigation packet on 06/17/2025 at 8:10 AM, revealed that the facility obtained six written statements from nursing staff who cared for Resident #140 from 03/04/2023 to 03/05/2023, and two statements from Private Duty Aides (PDAs), including the one who worked the 03/04/2023 night shift (PDA #17). However, no statements were obtained from other residents. The review of statements revealed that the last care was provided to Resident #140 around midnight on 03/04/2023, by a GNA and PDA, with no facial markings noted at that time. Around 5:30 AM on 03/05/2023, a GNA assisted the PDA again with care and noted a reddened area/rash on the right side of Resident #140's face. The GNA reported the area to the nurse. PDA #17's statement, written on 03/05/2024 at 11:04 AM via email, read: My last night's shift with [Resident #140's name] went well, I haven't worked with him/her before and I don't know how he/she looks like, much less knowing if he/she has injuries. And [Resident #140's name] did not fall in my shift because my eyes were on him/her the whole time. However, a review of the facility's follow-up self-report, submitted on 03/10/2023, on 06/17/25 at 8:10 AM indicated that the resident's face initially presented as a reddened area, like a rash, but by the morning of 03/06/2023, the area had developed into more pronounced bruising and swelling. It was initially thought that due to the resident's history of skin cancer, the area might have been developing into cancerous lesions. The sitter reported no problems during the hours in question. Upon speaking to the agency owner, the sitter admitted to him that he (sitter) fell asleep on his shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/17/2025 at 8:26 AM, during an interview with the Director of Nursing (DON), Nursing Home Administrator (NHA), and unit manager (Staff #2), the surveyor inquired about the process for investigating injuries of unknown origin. They explained that they interview staff who worked the previous three days, nurses conduct assessments, and if the incident is related to staff, they also interview other residents. The surveyor requested clarification on when other resident interviews were performed. The DON and NHA clarified that if the facility found the injury was caused by residents' known reasons (e.g., a reported red eye where the resident had a history of rubbing their eye prior to the incident), other resident interviews were not required. Furthermore, during the interview, the surveyor asked about Resident #140's injury of unknown origin reported on 03/05/2023. The DON stated that the resident did not have any episodes like a fall or intentional hitting prior to the reported discoloration. She said, The resident had a PDA who was hired by their family, so it was considered as a witness. That's why we didn't do other residents' interviews. The surveyor requested an explanation of the PDA's role and responsibilities. The DON and NHA stated that since PDAs were hired by the agency and/or residents' families, they were not facility employees. They stayed with residents, helping with feeding and assisting with daily activities alongside facility staff. They also added that facility staff encouraged them not to close doors at night, but the facility could not control them. The surveyor asked how the facility investigated the reported case of Resident #140's discolored right eye area on 03/05/2023, involving PDA #17. The NHA answered that they interviewed PDA #17, who wrote a statement, and the agency owner was contacted. The surveyor brought to their attention the discrepancy between PDA #17's written statement (claiming his eyes were on Resident #140 all night) and the facility's follow-up self-report (showing PDA #17 fell asleep on duty). Staff #2 stated she communicated with the agency owner via phone and discovered the fact. The surveyor requested supportive documentation for this. On 06/18/2025 at 8:35 AM, the NHA provided copies of emails from the PDA's company. The email, concerning Resident #140's unknown injury on 03/05/2023, stated: It was reported that [Resident #140] had sustained some bruising overnight. The caregiver assigned to his overnight care admitted to falling asleep during the shift. As a result, we immediately removed this caregiver from the resident's care. The caregiver is also prohibited from providing overnight care to any of our clients moving forward. On 06/18/2025 at 1:38 PM, the DON confirmed that this printed email was written by the agency company today (06/18/2025). The facility had no documentation to support their further action and/or investigation regarding PDA #17. Additionally, the part of the email copy provided to the surveyor contained notes regarding PDA #17 falling asleep on the job and being prohibited from working any more overnights, dated 08/28/2023, which was more than five months after the incident was reported. During an interview with the NHA, DON, and the [NAME] President of the facility on 06/20/2025 around 3 PM, the surveyor shared concerns that Resident #140's reported discoloration around the right half of the face was not thoroughly investigated. They validated this concern.