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	03/30/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of 2 facility reported incidents, all pertinent facility documentation and staff interview, it was determined that the facility failed to report allegations of staff to resident abuse to local law enforcement. This was found to be evident for 2 (Resident #1 and Resident #2) of 2 residents reviewed during a complaint survey. The findings include: 1) On 08/20/25 the Office of Health Care Quality received a facility reported incident regarding an allegation that a resident was a victim of physical abuse. A review of the facility investigation on 03/30/26 revealed that the facility became aware of an allegation of staff to resident physical abuse on 08/20/25 at 2:30 pm. The facility received the allegation of physical abuse from one of the construction company foremen who was completing renovations on the skilled nursing unit. The foreman stated that one of the construction staff witnessed a staff member hitting Resident #1 in the head sometime during the previous week. Further review of the facility investigation revealed that on 08/22/25 at approximately 11:45 am pm, the construction foreman wrote in the email that they heard crying and pleas for help accompanied by noises resembling slapping coming from Resident #1's room on 08/20/25 at 2:25 pm. The construction foreman indicated in the email they felt strongly that someone in Resident #1's room was being assaulted during the times they heard crying and pleas for help. At 2:50 pm on 08/20/25, the construction foreman indicated they informed one of the facility staff members in the parking lot of what they heard and what was reported to them days earlier. 2) On 07/23/25 the Office of Health Care Quality received a facility reported incident, #2569932, regarding an allegation of possible mistreatment. Resident #2 was identified with a fractured right femur (an injury of unknown source). Resident #2 was admitted to the facility on [DATE] with diagnoses that include but not limited to vascular dementia (Vascular dementia is a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, robbing brain cells of oxygen), glaucoma (poor vision), and a history of bilateral knee replacements (Bilateral knee replacements involves replacing both knee joints, either simultaneously or in stages, for patients with severe arthritis to improve mobility). Resident #2 was deemed incapable of being able to make medical decisions by two physicians in November of 2022.A review of the facility investigation on 03/30/26 revealed that the facility became aware of an injury of unknown source on 07/11/25 at 9:27 pm when Resident #2 was identified with a fractured right distal femur. Resident #2 was unable to inform the facility staff with any information or details as to when or how the fractured femur may have occurred. Further review of the facility investigation revealed that the local police had not been notified of an allegation of possible mistreatment/injury of unknown source. In an interview with the facility DON on 03/30/26 at 2:10 pm, the facility DON stated the facility did not report the allegation of abuse/mistreatment in either of the facility reported incidents #2595992 and #2569932 to the local police.

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

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	03/30/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 allegation of physical abuse. This was evidenced by 1 (Resident #1) of two residents reviewed during a complaint survey. The findings include: On 08/20/25 the Office of Health Care Quality received a facility reported incident regarding an allegation a resident was a victim of physical abuse. Resident #1 was admitted to the facility on [DATE] with diagnoses that include but are not limited to dementia with aggression. Resident #1 had a BIMS score of 5/15 which indicates severe cognitive impairment. The BIMS (Brief Interview for Mental Status) score is a 0-15 point tool used in healthcare, particularly long-term care, to assess cognitive function, with higher scores indicating better cognition. It evaluates immediate recall, temporal orientation, and short-term memory. A score of 13-15 indicates intact cognition, 8-12 moderate impairment, and 0-7 severe impairment. A review of the facility investigation on 03/30/26 revealed that the facility became aware of an allegation of staff to resident physical abuse on 08/20/25 at 2:30 pm. The facility received the allegation of physical abuse from one of the construction company foremen completing renovations on the skilled nursing unit. The foreman stated that one of the construction staff witnessed a staff member hitting Resident #1 in the head sometime during the previous week. On 08/22/25, during the facility investigation, the construction company foreman sent an email to the facility regarding the allegation of staff to resident physical abuse. In the email, the construction foreman indicated elaborated on the construction staff's original statement. In the email, the construction staff reported that they had heard crying and pleas for help coming from Resident #1's room. As they approached the area, they claimed to have witnessed what appeared to be the staff member striking an elderly wheelchaired patient. The construction foreman indicated that they made a note of the incident and decided to keep an eye and an ear on any cries coming from that corridor. On 08/20/25 at approximately 2:225 pm, the construction foreman wrote in the email that they heard crying and pleas for help accompanied by noises resembling slapping coming from Resident #1's room. The construction foreman indicated in the email they felt strongly that someone in Resident #1's room was being assaulted during the times they heard crying and pleas for help. At 2:50 pm on 08/20/25, the construction foreman indicated they informed one of the facility staff members in the parking lot of what they heard and what was reported to them days earlier. In an interview with the facility director of nurses (DON) on 03/30/26 at 11:40 am, the DON indicated the alleged perpetrator was a private duty assistant (Staff#1) hired by Resident #1's family. The DON stated that the facility did not have any type of human recourse records for Staff#1 including abuse training, background checks, or licensing information for Staff #1. In a follow-up interview with he facility DON on 03/30/26 at 2:10 pm, the facility DON stated the facility investigation did not have separate facility conducted interviews with each of the construction staff.

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	03/30/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of a facility investigation and record review, and staff interview, it was determined that the facility failed to implement an intervention, determined to be necessary, for a resident who was identified as a fall risk. This was evident of 1 (Resident #2) of 2 residents reviewed during a complaint survey. The findings include: On 07/23/25 the Office of Health Care Quality received a facility reported incident, #2569932, regarding an allegation of possible mistreatment. Resident #2 was identified with a fractured right femur (an injury of unknown source). Resident #2 was admitted to the facility on [DATE] with diagnoses that include but not limited to vascular dementia (Vascular dementia is a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, robbing brain cells of oxygen), glaucoma (poor vision), and a history of bilateral knee replacements (Bilateral knee replacements involves replacing both knee joints, either simultaneously or in stages, for patients with severe arthritis to improve mobility). Resident #2 was deemed incapable of being able to make medical decisions by two physicians in November of 2022. Resident #2 is non-ambulatory and requires the use of a mechanical lift for all transfers in and out of bed. Resident #2 is also dependent upon the nursing staff for all activities of daily living. A review Resident #2 medical record on 03/30/26 revealed a physician's order, dated 03/08/2024, instructing the nursing staff to use a Hoyer (mechanical lift) lift for all transfers. A review of Resident #2's fall prevention/ADL care plans on 03/30/26 revealed a nursing intervention, dated 07/31/24 indicating the nursing staff are to use a Hoyer (mechanical lift) lift for all transfers. A review of the facility investigation on 03/30/26 revealed that the facility became aware of an injury of unknown source on 07/11/25 at 9:27 pm when Resident #2 was identified with a fractured right distal femur. Resident #2 was unable to inform the facility staff with any information or details as to when or how the fractured femur may have occurred. A review of the facility investigation on 03/30/26 revealed that the facility administrative staff viewed surveillance camera footage of the nursing units and in particular Resident #2 hallway footage. A review of GNA #1's employee warning notice, dated 07/14/25, the DON and unit manager interviewed GNA #1 about using a Hoyer lift and a second staff member with Resident #2's transfer on 07/07/25 during the 3-11 pm shift. Initially, the employee warning notice indicated, GNA #1 stated that they used a Hoyer lift with a second staff member on 07/07/25 during the 3-11 pm shift when transferring Resident #2. Then later, the employee warning notice indicated GNA #1 admitted to using only themselves when transferring Resident #2 on 07/07/25 during the 3-11 pm shift. In an interview with the facility director of nurses (DON) on 03/30/26 at 2:30 PM, the DON indicated that during the investigation into Resident #2's fracture femur, the administrative staff reviewed facility camera footage covering the entrance to Resident #2 rooms. The DON stated that the administrative staff viewed GNA#1 enter Resident #2's room, alone, with a Hoyer lift (mechanical lift) and after a period of time observed GNA #1 exit the room, alone, with the Hoyer lift. The DON stated that at not time did the administrative staff witness a second staff member entering the room to assist GNA #1 with Resident #2's transfer.