

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Lorien Health Systems - Columbia		STREET ADDRESS, CITY, STATE, ZIP CODE 6334 Cedar Lane Columbia, MD 21044	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on Facility Reported Incident (FRI) file (2696293) review, record review and staff interview, it was determined the facility failed to report an unknown origin injury to the State Agency, the Office of Health Care Quality (OHCQ), immediately but not later than 2 hours after the facility was made aware of the injury's severity. This was evident for 1 (Resident #208) out of 5 residents reviewed for incidents during an annual survey. The findings include: Facility Reported Incident file review, on 1/14/2026 at 09:00 AM, it was noted that the initial report was filed with the State Agency on 12/8/2025 at 9:54 AM. The facility's investigation report contained only one on-duty staff incident statement and two staff email statements regarding an unknown origin injury involving Resident #208 on 12/06/2025 at approximately 4:00 PM. Evidently the Resident was reported to be screaming in severe pain in their left hip and was subsequently transported to a nearby hospital. Records from 12/07/2025 indicate that the facility Charge Nurse Staff #41 and the Unit Manager Staff #42 were informed that the hospital diagnosed Resident #208's injury with a left hip fracture. Interview, on 01/14/26 at 10:09 AM, Charge Nurse Staff #41 reported that on 12/07/2025 she encountered the resident's family picking up personal belongings. At that time, she learned that Resident #208 had sustained a severe left hip fracture. During the interview, on 01/14/26 at 01:01PM, the Administrator confirmed that facility staff was made aware of Resident #208's severe injury of unknown origin on 12/07/2025, however, the initial self-report was not submitted to the State agency until 12/8/2025. This was non-compliant with the FRI reporting requirements, which dictated that the Office of Health Care Quality (OHCQ) must be notified immediately, and no later than two hours after the facility became aware of a severe injury. In this instance, the report was filed one day late. The Administrator agreed with this finding of deficient practice.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on Facility Reported Incident file (2696293) review, record reviews, and interviews, it was determined that the facility failed to thoroughly conduct investigations regarding a severe injury of unknown origin. This was evident for 1 (Resident #208) out of 5 residents reviewed for incidents during an annual survey. The findings include: Facility Reported Incident file review, on 1/14/2026 at 09:00 AM, it was noted that the initial report was filed with the State Agency on 12/8/2025 at 9:54 AM. The facility's investigation report contains only one on-duty staff incident statement and two staff email statements regarding an incident involving Resident #208 on 12/06/2025 at approximately 4:00 PM. Evidently the Resident was reported to be screaming in severe pain in their left hip and was subsequently transported to a nearby hospital. Records from 12/07/2025 indicated that the facility Charge Nurse Staff #41 and the Unit Manager Staff #42 both were acknowledged that the hospital diagnosed Resident #208's injury with a left hip fracture. Interview, on 01/14/26 at 10:09 AM, Charge Nurse Staff #41 reported that on 12/07/2025 she encountered Resident #208's family picking up personal belongings. At that time, she learned that the resident had sustained a severe left hip fracture. However, she did not notify the Administrator until 12/08/2025 nor she started further investigation staff/ residents' interviews. During an interview on 01/14/2026, at 01:01PM, the Administrator disclosed that Staff #42 withheld information regarding the severe injury of unknown origin of Resident #208. Despite the severity of the injury, no further investigation was conducted. The Administrator confirmed that a thorough investigation was not completed, and interviews with the relevant shift staff and residents on the same floor were not conducted. The Administrator was informed that these findings represent concerns regarding the facility failing to thoroughly conduct investigations.</p>		