STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215117	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stella Maris, Inc.	2300 Dulaney Valley Road Timonium, MD 21093

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to ensure dignity was maintained for Resident #55 and Resident #84. This was evident for 2 residents out of 9 residents reviewed for activities of daily living during the facility's annual survey.The findings include: 1) On 07/15/2025 at 3:30 PM, during the surveyor's follow-up observation rounds of the 1st Floor [NAME] Unit, while also accompanied by the Unit Manager #22, Resident #55 was observed from the hallway through the completely ajar door, and no privacy curtain in use. Resident #55 was seated in a wheelchair next to the bedside, while Wound Nurse #21 was performing wound care to the resident's left lower extremity. On 07/15/2026 at 3:31 PM, the surveyor conducted an interview of Unit Manager #22, who confirmed the same observation of the Wound Nurse #21 performing wound care to Resident #55's left lower extremity with no privacy curtain and door open, with Resident #55 able to be seen from the hallway during dressing changes. Unit Manager #22 stated this is not the expectation of wound care for the residents, and it would be reported to the Director of Nursing #2. On 07/23/25 at approximately 3:00 PM, the surveyor shared the concern of maintaining privacy for dignity for the resident during the exit conference with the facility's Administrator, Director of Nursing, and Executive Director. 2) On 7/15/25 at 9:54 AM, during the surveyor's tour of the Ground [NAME] Unit, Resident #84 was observed by the surveyor from the hallway to be lying in bed asleep with their Hoyer lift sling wrapped under and surrounding them with no staff present. Resident #84's breakfast meal was observed sitting on their bedside table, uncovered, and appeared to be uneaten. At this time, the surveyor proceeded to find unit staff to share the concern. On 7/15/25 at 9:55 AM, the surveyor requested that Unit Manager #17 perform a dual observation of the concern with them. Unit Manager #17 observed Resident #84 with the surveyor and acknowledged understanding of the surveyor's concerns and confirmed with the surveyor that they expected that it was not acceptable for the sling to be left on the resident when in bed, and additionally confirmed the resident required staff feeding assistance to eat. On 7/15/25 at 9:58 AM, Geriatric Nursing Assistant (GNA) #18 was observed pushing a rolling bedside table down the hallway, collecting dirty breakfast dishes. At this time, Unit Manager #17 informed GNA #18 of the surveyor's concern. Unit Manager #17 stated to the surveyor that GNA #18 had gone to find help from another staff member because the resident required the transfer assistance of two staff. However, the surveyor noted that GNA #18 was observed collecting dirty dishes and had not (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	returned to the room with any additional staff. On 7/15/25 at 9:59 AM, the surveyor conducted an interview of GNA #18, who stated the following to the surveyor: I was going to look for someone to help. When the surveyor inquired as to what staff member they had asked to assist them, they responded: I'm gonna get somebody, I'm going to get another GNA. On 7/17/25 at 12:44 PM, the surveyor shared the concern with the facility's Director of Nursing. On 7/23/25 at approximately 3:00 PM, the surveyor shared the concern during the exit conference with the facility's Administrator, Director of Nursing, and Executive Director.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on medical record review, staff interviews, and the facility's investigation, it was determined that the facility failed to ensure Resident #199 was free from verbal abuse by staff. This deficient practice was evident for 1 of 5 residents reviewed for abuse during the recertification survey. The facility implemented corrective measures following this incident, therefore, this deficiency will be cited as past noncompliance. The date of correction was 6/7/25.Findings include:The facility-reported incident was reviewed on 7/21/25 at 10:00 a.m. The investigation revealed that on 4/15/25, at approximately 11:10 p.m., Resident #199 reported that GNA Staff #25 called the resident fat and questioned the resident about not being able to hold urine and stool. Medical record review revealed that the resident was incontinent.During interviews, Witness GNA (Geriatric Nursing Assistant)#27 stated GNA Staff #25 was angry and repeatedly called Resident #199 names related to the resident's incontinence, expressing frustration over the need to use the sit-to-stand lift instead of performing a stand/pivot transfer.The facility's investigation substantiated the allegation of verbal abuse. GNA Staff #25 was immediately suspended, terminated from employment, and reported to the Board of Nursing. Additionally, the facility notified the police, Ombudsman, attending physician, and the resident's emergency contact.During an interview with the Director of Nursing on 7/21/25 at 12:00 p.m., she confirmed that the verbal abuse had been witnessed by another staff member, was substantiated, and resulted in termination and mandatory reporting of the GNA.Although the deficient practice resulted in Resident #199 experiencing verbal abuse, the facility took immediate corrective action at the time of the incident. The staff member was removed from duty, terminated, and reported to the appropriate agencies. All required notifications were completed. The facility's corrective measures were implemented and completed prior to the start of the current survey; therefore, this deficiency is cited as Past Non-Compliance.

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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. Based on record reviews and interviews, it was determined that the facility failed to report an allegation of abuse and an injury of unknown origin to the Office of Health Care Quality (OHCQ) within the specified timeframe. This was evident for 2 residents (Resident #177 and Resident #161) out of 10 residents investigated for Facility Reported Incidents during this facility's annual survey.The findings include: 1) On 07/18/25 at 8:32 AM, during the facility's reported incident record review, it revealed the facility reported to OHCQ on 07/02/25 at 4:55 PM that GNA #23 stated they observed GNA #23 hit Resident #177 at approximately 9:00 AM. On 07/23/25 at 9:03 AM, the surveyor conducted an interview with Director of Nursing #2 regarding the delay in reporting alleged physical abuse to OHCQ; stated they are aware there was a delay in the time of reporting to OHCQ. On 7/23/25 at approximately 3:00 PM, the surveyor shared the concern of delayed reporting to OHCQ during the exit conference with the facility's Administrator, Director of Nursing, and Executive Director. 2) Review of Resident #161's medical record review and other pertinent documentation on 07/18/2025 at 10:00 AM revealed a doctor progress note dated 06/05/2025 that the resident had persistent left knee pain with difficulty bending the joint. An X-ray was negative for acute findings, and an MRI (Magnetic Resonance Imaging) was ordered for further evaluation on 06/18/2025. Further review revealed the MRI of the left knee without contrast was performed on 06/18/2025, and results revealed a nondisplaced vertical/oblique fracture through the anterolateral distal femur. A doctor's progress note dated 07/03/2025 states the resident did not have any fall; the mechanism of injury suggests a pathological fracture, and a DEXA scan would be obtained to evaluate for Osteoporosis. During an interview on 07/21/2025 at 09:37 AM, the Director of Nursing stated that the facility did not know how or why Resident #161 sustained a left leg nondisplaced vertical/oblique fracture through the anterolateral distal femur, but a DEXA scan had been scheduled and had not been done as of 07/21/2025 on Resident#161. During an interview on 07/21/2025 at 10:45 AM, the Administrator and Director of Nursing stated to the surveyor that there was no report made to the Office of Health Care Quality regarding Resident #161's fracture/injury of unknown origin.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Number of residents sampled: Number of residents cited: Based on medical record review and staff interview it was determined the facility staff failed to notify the resident/resident representative (RP) in writing of a transfer/discharge of a resident along with the reason for the transfer. This was evident for 1 (#90) of 5 residents reviewed for hospitalization during a recertification. The findings include: During the investigation of Complaint 339997 on 7/17/25 at 10am revealed Resident #90 was recently hospitalized . On 7/17/25 at 10:15 am a review of nurses' progress notes and change in condition documentation dated 6/18/25 at 01:05 am revealed Resident #90 was sent to the ER (emergency room) via 911 on 6/18/25.However, there was no documentation/evidence that the resident and/or RP were notified in writing about the reason for transfer to the hospital. On 7/17/25 at 11:15 AM an interview was conducted with the Nursing Home Administrator regarding written notification of reason for transfer to the hospital, she stated that the reason for transfer was documented in the change in condition form included in the transfer packet sent with the resident to the hospital. She stated that the resident was notified verbally of the reason for the transfer to the hospital. During a follow-up interview with the Nursing Home Administrator (NHA) on 7/18/25 at 3:47 PM, the Surveyor was informed that the facility was unable to provide documentation to verify that Resident #90 and /or their RP received in writing the reason of the transfer to the hospital on 6/18/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of medical records and interviews, it was determined that the facility failed to ensure that a resident who required a Hoyer lift for transfer was transferred correctly. This was evident for 1 (Resident #161) out of 8 residents reviewed during the survey.The findings include the following:During an interview on 07/16/2025 at 4:00 PM Resident #161 alleged that staff assisted him/her into the wheelchair and because of the transfer sustained a left lower extremity fracture.Review of Resident #161's medical record on 07/18/2025 at 9:55 AM revealed a care plan with a focus area that was initiated on 12/31/2024 stating that resident had an ADL self-care performance deficit related to right above the knee amputation and muscle weakness with an approach that resident requires Mechanical Lift (Hoyer) with 2 staff assistance for transfers.Review of Resident #161's medical record and other pertinent documentation on 07/18/2025 at 10:00 AM revealed that on 05/09/2025 prior to going to dialysis, Staff #7 and #8 assisted and transferred the resident using stand/pivot to a wheelchair and did not use a Hoyer lift. While performing this transfer the resident stated ouch and that staff #8 had stepped on his/her foot but was ok.Per facility progress note dated 05/09/2025 at 18:36 PM, resident returned to facility from dialysis in stable condition and denied pain. Per facility progress note dated 05/10/2025 at 09:25 AM resident complained of left leg/foot pain, the doctor was notified and new orders for stat x-ray to left leg and foot were given and as well resident was medicated for pain. Radiology Results Report dated 05/10/2025 revealed no evidence of fracture. During an interview on 07/18/2025 at 2:27 PM the Director of Nursing stated and confirmed that on 05/09/2025 staff #7 and #8 failed to transfer Resident #161 with a Hoyer lift. During review of facility investigation staff statements on 07/21/2025 at 10:05 AM revealed that Staff #7 and #8 were aware that Resident #161 required a 2 person Hoyer lift and had participated in the stand, turn pivot transfer of Resident #161 on 05/09/2025 prior to going to dialysis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record reviews and interviews, it was determined that the facility failed to ensure that resident medical records were accurate. This was evident for 2 (Resident #310 and #84) out of 6 residents reviewed during the facility's recertification survey.The findings include: 1. On 07/18/25 at 10:56 AM, review of resident records revealed that Resident #310's care plan referred to Resident #310 as [incorrect resident name]. On 07/18/25 at 12:38 PM, the Director of Nursing staff #2 was interviewed. During the interview, Staff #2 was made aware that Resident #310's care plan referred to Resident #310 with the incorrect resident name. Staff #2 stated that the facility will correct Resident #310's care plan. 2. During an interview on 7/15/25 at 9:58AM Unit Manager #17 stated to the surveyor that GNA #18 had went to find help from another staff member because the resident required the transfer assistance of two staff. On 7/17/25 at 11:45AM the surveyor reviewed the medical record of Resident #84 which revealed the following care plan intervention in place dated as initiated on 5/19/25 by Licensed Practical Nurse (LPN) #19: TRANSFER: The resident requires Mechanical Lift/Hoyer transfer by 1-2 staff assistance for transfers. Review of the facility's safe transfers policy by the surveyor on 7/17/25 at 12:00PM revealed the following documented information: PROCEDURE: Mechanical Lifts: .All mechanical lift activities require two-person trained staff during the transfer process, .Hoyer Lifts: Two-person transfer is required for all Hoyer Lift transfers from the initiation of the lift pad to the end product of the lifting process. Review on 7/17/25 at 12:03PM of the facility's nursing education department clinical orientation packet for geriatric nursing assistants was provided by the facility's Director of Nursing (DON) in response to an inquiry made by the surveyor as to training provided to Geriatric Nursing staff upon hire with regard to the use of Hoyer Lifts revealed a document titled: Mechanical Lift practice session which included the following information regarding use of the mechanical lift: Two person use ALWAYS. On 7/17/25 at 12:44PM the surveyor conducted an interview of the facility's DON and inquired to them as to why the care plan intervention for Resident #84 stated 1-2 assistance for transfers when they required a mechanical lift, to which they replied: It should say 2 person assist. At this time the surveyor shared their concern with the DON who acknowledged and confirmed understanding of the concern. On 7/18/25 at 10:14AM the surveyor conducted another interview of the Director of Nursing who stated the following information to surveyors: the care plan of 1-2 assist was in error, the nurse toggled 1-2, It was corrected on the care plan. When the surveyor further inquired as to the toggling required, the Director of Nursing stated: s/he (Licensed Practical Nurse #19) wrote that. On 7/18/25 at 10:30AM the surveyor reviewed documentation provided by the facility's Administrator and DON which revealed the following care plan intervention for Resident #84 which was revised by (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the Director of Clinical Informatics #20 on 7/17/25: TRANSFER: The resident requires Mechanical Lift/Hoyer transfer by 2 staff assistance for transfers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to maintain an infection prevention and control program to provide a safe and sanitary environment. This was evident for 3 residents (#161, #3, #55) out of 9 residents investigated during the survey.The findings include:Enhance Barrier Precautions (EBP): Enhanced Barrier Precautions are used as an infection control intervention that uses targeted gown and glove use during high-contact resident care activities in nursing homes to reduce the transmission of multidrug-resistant organisms (MDROs).1. On 07/15/2025 at 3:30 PM during the surveyor's follow-up observation rounds of the 1st Floor [NAME] Unit, while also accompanied by the Unit Manager #22, Resident #55 was observed in the room from the hallway through the completely ajar door and no privacy curtain in use. There was an Enhanced Barrier Precaution sign present on the door. Resident #55 was seated in a wheelchair next to the door-side bed, while Wound Nurse #21 sat cross-legged directly on the bare floor and had dressing gauze supplies directly on the bare floor while performing wound care to the resident's left lower extremity; no protective barrier was observed on the floor under the staff or the dressing supplies.On 07/15/2026 at 3:31 PM the surveyor conducted an interview of Unit Manager #22 who confirmed the same observation of the Wound Nurse #21 and the wound care supplies on the bare floor during dressing changes to Resident #55 left lower extremity. Unit Manger #22 stated Wound Nurse #22 would be reported to the Director of Nursing #2.On 07/16/2025 at 3:46 PM surveyor conducted an interview with Director of Nursing #2, who stated that the wound care dressings were redone, and specimens were taken of the wound, and Wound Nurse #21 received disciplinary actions.On 07/22/25 at 1:30 PM during record review it revealed Wound Care #21 received a final written warning for being observed on 07/15/25 doing a heel dressing with resident in chair. Supplies were on the floor and in-service training ?Infection Control-Skills Validation' on 07/16/25.2. On 07/15/25 9:25 AM During observation rounds, no Enhanced Barrier Precautions signs were observed on the door of Resident #161 & #3.On 07/16/25 9:09 AM During medical record review it revealed Resident #161 orders for Enhanced Barrier Precautions related to dialysis catheter. Use precautions during high-risk activities No room restriction is required every shift; ordered on 07/09/25 at 19:00.On 07/16/25 9:15 AM During medical record review it revealed Resident #3 orders for Enhanced Barrier Precautions related to multiple wounds. Use precautions during high-risk activities No room restriction is required every shift; ordered on 06/27/25 at 19:00.On 07/23/25 at approximately 3:00PM the surveyor shared the concern of maintaining infection control and prevention for the residents during the exit conference with the facility's Administrator, Director of Nursing, and Executive Director.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents. This was evident for 1 unit out of 9 units investigated during the survey.The findings include:1. On 07/15/25 at 9:21 AM during observation rounds on 1st Floor [NAME] the surveyor observed rooms 164, 166, 168, and 170 bathroom vents were with approximate 1 thick gray fuzzy matter. On 07/15/2025 10:30 AM during interview Unit Manager #22 notified of findings and was informed a request for cleaning was mentioned at the last Ops Meeting in June. On 07/15/2025 at 12:15 PM during interview Nursing Home Administrator #1 and review of facility records it revealed the Ops meeting minutes, held 06/20/25 indicated Nursing Updates: vents in 1K need to be cleaned.2. On 07/15/25 at 9:22 AM during observation rounds on 1st Floor [NAME] Unit the surveyor observed in room [ROOM NUMBER] bathroom with a gouged-out area to the wall approximately 1 1/2 ft. x 1/2 ft. with visible plaster disruption to the wall adjacent to the toilet just above the cove base.On 07/15/25 at 10:30 AM during interview with Unit Manager #22, who was notified of hole in room [ROOM NUMBER] bathroom wall and agreed it was not like a comfortable environment.3. On 07/15/25 at 10:15 AM during observation rounds on 1st Floor [NAME] Unit the surveyor observed in room [ROOM NUMBER] bathroom an over-the-toilet commode with chipped paint revealing brown area to the lateral bar that would potentially meet a resident's lower extremity while commode in use.On 07/15/25 at 11:00 AM during interview with Unit Manager #22, who was notified of chipped paint revealing brown area to lateral bar on over-the-toilet commode in room [ROOM NUMBER] bathroom and agreed this it was not like a comfortable environment.On 07/23/25 at approximately 3:00PM the surveyor shared the concern of maintaining a safe, functional, sanitary, and comfortable environment for residents during the exit conference with the facility's Administrator, Director of Nursing, and Executive Director.