

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Stella Maris, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 Dulaney Valley Road Timonium, MD 21093	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, it was determined that the facility failed to: (1) ensure oxygen tubing and related oxygen delivery equipment were consistently dated and labeled in accordance with professional standards of practice; and (2) ensure a physician's order was available for oxygen administration for a resident receiving oxygen therapy. This deficient practice was evident for 5 (Residents #29, #87, #287, #3, and #6) of 5 residents reviewed for oxygen therapy during the facility's recertification survey. The findings include: Oxygen tubing is the flexible plastic line that safely delivers supplemental oxygen from a source like a portable tank, liquid oxygen system, or stationary concentrator directly to the user. It connects directly to a nasal cannula or face mask and comes in various lengths for daily use. A nasal cannula is a lightweight, flexible plastic device used to deliver supplemental oxygen to people who have difficulty breathing. It features two small prongs that rest directly inside your nostrils, connected to tubing that loops over the ears and rests comfortably under the chin. A humidifier is a device that adds water vapor to the air to increase indoor humidity. It is commonly used to combat dry air caused by winter heating or air conditioning, which can help relieve dry skin, chapped lips, and irritated nasal passages. 1) On 07/21/2026 at 9:30 AM, during the initial tour of the facility, the surveyor observed Resident #29 receiving oxygen via nasal cannula. Observation of the oxygen equipment revealed that the oxygen tubing was not labeled or dated. On 07/21/2026 at 9:32 AM, the 3P Unit Manager was interviewed. She stated that it was the facility's expectation that all oxygen tubing be changed according to physician orders and labeled with the date it was changed. The surveyor informed the Unit Manager that Resident #29's oxygen tubing was not labeled or dated. The Unit Manager acknowledged the observation. On 07/21/2026 at 9:43 AM, during continued tour of the facility, the surveyor observe Resident #87 receiving oxygen therapy via nasal cannula. The humidifier and nasal cannula were observed without a date or label. On 07/21/2026 at 10:42 AM, the surveyor requested a dual observation with Ground [NAME] Unit Manager and she confirmed that the oxygen tubing and humidifier were not dated or labeled. When (continued on next page)		

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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asked regarding the facility's expectation for dating and labeling oxygen equipment, she stated that the equipment was expected to be changed weekly and dated/labeled after the change. On 07/21/2026 at 11:26 AM, during continued tour of the facility, Resident #287 was observed receiving oxygen therapy via nasal canula. The oxygen tubing/nasal canula was observed without a date or label. On 07/21/2026 at 11:30 AM, Resident #3 was observed receiving oxygen therapy via nasal canula. The oxygen tubing/nasal canula was observed without a date or label. On 07/21/2026 at 11:37 AM, during an interview with the Unit Manager for [NAME] 1, when asked when the oxygen tubing/nasal cannula for Residents #287 and #3 was last changed, the Unit Manager stated that she did not know and would follow up. During a dual observation, the Unit Manager confirmed that the oxygen tubing/nasal cannula for both residents was not labeled. When asked regarding the facility's expectation for oxygen equipment labeling, the Unit Manager stated that oxygen tubing should be dated and labeled after each change. On 07/23/2026 at 8:42 AM, the surveyor reviewed the facility policy titled Oxygen Therapy. Under the Procedure section, item #8 stated, Oxygen tubing, mask, and/or cannula are changed weekly and when soiled. Label and date all tubing. On 07/24/2026 at 9:15 AM, during an interview with the Director of Nursing (DON), when asked regarding the facility's expectation for dating and labeling oxygen equipment, the DON stated that the standard practice was for oxygen tubing and humidifiers to be changed weekly and dated/labeled after each change. When informed of the findings, the DON acknowledged the concern. 2) On 7/22/2026 at 8:37 AM, an observation of Resident #6 was conducted. The resident was observed to be on oxygen therapy delivered via nasal canula. The resident stated that the oxygen therapy was started in the hospital and continued after being admitted to the facility. On 7/24/2026 at 8:28 AM, a review of Resident #6's orders was conducted. The resident had a parameter order for the Oxygen therapy to Start to Wean Oxygen as tolerated to maintain SPO2 of 92% started 7/15/2026. There were no orders specifying the specific liters of oxygen to be administered, the route of administration, or the frequency of the administration. On 7/24/2026 at 12:15 PM, an interview with the Director of Nursing (DON) was conducted. When asked if a resident receiving oxygen should have an order in the chart to specify the administration of oxygen, the DON stated that there should be an order for oxygen in the resident's chart. The DON confirmed that Resident #6 did not have an oxygen administration and stated that they would address this after surveyor intervention. On 7/27/2026 at 1:30 PM, a review of Resident #6 orders was conducted. An order for Oxygen to be given continuously at 2 liters per minute for hypoxia via nasal cannula every shift was started on 7/24/2026 at 7:00 PM.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to develop and implement a hospice care plan for a resident admitted to hospice services. This deficient practice was evident for 1 (Resident #17) of 1 resident reviewed for hospice services during the facility's recertification survey. The findings include: A care plan is a written, individualized document that identifies a resident's assessed needs, goals, preferences, and the specific interventions and services required to meet those needs. It serves as a communication tool for the interdisciplinary team to ensure consistent, coordinated, and person-centered care. On 07/22/2026 at 11:37 AM, review of Resident #17's electronic medical record revealed the resident was admitted to hospice services on 07/09/2026. However, a hospice care plan was not identified in the electronic health record. On 07/22/2026 at 11:52 AM, review of Resident #17's paper medical record located on the nursing unit also failed to identify a hospice plan of care. On 07/22/2026 at 12:11 PM, during an interview, the Unit Manager for 1 [NAME] stated that Resident #17 had been admitted to hospice on 07/09/2026. When asked who was responsible for overseeing care plans, she stated that the interdisciplinary team shared responsibility. When asked who was responsible for updating the nursing portion of the care plan, she stated that responsibility was hers. When asked whether Resident #17 had a hospice care plan, she reviewed the resident's electronic health record and stated that no hospice care plan had been initiated. When asked whether Resident #17 should have had a hospice care plan in place, she stated yes and explained that The social Worker assigned to Ground [NAME] and 1 [NAME] units (Staff #9) should have initiated the hospice care plan and that she should have notified Staff #9 to ensure the care plan was developed. On 07/22/2026 at 12:28 PM, during an interview, Staff #9 (the Social Worker assigned to the Ground [NAME] and 1 [NAME] units) stated that either the Social Worker or Unit Manager could initiate the hospice care plan; however, it was her responsibility to verify completion. Staff #9 confirmed that Resident #17 had been admitted to hospice services on 07/09/2026 and stated that a hospice care plan should have been initiated. When asked when the hospice care plan should have been developed, Staff #9 stated that it was typically initiated upon notification of hospice admission. When asked whether she had been notified of Resident #17's hospice admission, Staff #9 stated that she was aware of the admission but was unsure why the hospice care plan had not been initiated. On 07/22/2026 at 12:49 PM, the concern was discussed with the Director of Nursing (DON) and the Administrator. Both acknowledged the findings. On 07/22/2026 at 1:47 PM, following surveyor intervention, Staff #9 initiated a hospice care plan for Resident #17 and provided a copy of the completed hospice care plan to the surveyor.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews and review of records, it was determined that the facility failed to administer and document medications as prescribed. This was evident for 2 (Resident #173 and #200) out of 3 residents who were reviewed for medication administration during the recertification survey. The findings include: 1). On 07/21/2026 at 10:17 AM, an interview with Resident #173 was conducted. The resident reported that their medications were administered late. The resident was unable to recall any dates or timeframes. On 07/22/2026 at 12:13 PM, a review of the medication administration audit for the last 7 days (July 13th to July 21st) was conducted. The review revealed the following:-Eliquis Oral Tablet 5 MG (Apixaban) and Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) were ordered to be given at 7 AM. Both medications were given late 6 out of 7 days. -Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 1 tablet by mouth one time a day for hypertension ordered for 9am was administered late 7 out 7 days. On 07/21/2026 at 9:45 AM, an interview with Resident #200 was conducted. They reported that their medications were administered late. They reported this happened several days about 2 weeks ago. 2). On 07/22/2026 at 1:51 PM, a review of Resident #200's medical record was conducted. The review revealed that the resident had the following active medication orders: -Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for Atrial Fibrillation. -Furosemide Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth in the morning for Congestive heart failure. -Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for Atrial Fibrillation. A review of the July 1st to July 7th 2026, medication administration audit was conducted. The review revealed the following: On 7/2/2026 Apixaban Oral Tablet 5 MG ordered for 8 AM, Furosemide Oral Tablet 40 MG ordered for 9 AM and Metoprolol Tartrate Oral Tablet 25 MG ordered for 9 AM were given at 12:05 PM and documented at 12:07 PM. On 7/3/2026 Apixaban Oral Tablet 5 MG ordered for 8 AM, Furosemide Oral Tablet 40 MG ordered for 9 AM and Metoprolol Tartrate Oral Tablet 25 MG ordered for 9 AM were administered at 2:47 PM and documented at 2:48 PM. On 07/22/2026 at 1:16 PM, an interview with the Unit Manager was conducted. She reported that facility staff are expected to administer medications an hour before or after the ordered time and document the drug administration in real time. The surveyor reviewed the medication administration record audit with the unit manager who confirmed that the medications were administered late. On 07/24/2026 at 9:14 AM, a follow up interview with the Director of Nursing (DON) was conducted. She clarified that the facility had a liberal medication pass timeframe. Therefore, medications ordered for 7am could be administered until 11am. However, if a medication was ordered outside the liberal time frames, 7 am or 11am for morning shifts, then the medication were to be given an hour before or an hour after the ordered time. The medication administration audits for Resident #173 and #200 were reviewed with the DON who verbalized understanding of the concerns.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, policy review, and staff interviews, it was determined that the facility failed to: (1) consistently maintain the required separate written reports of medication regimen review irregularities, and (2) ensure documentation was available to demonstrate that pharmacist-identified medication regimen review irregularities had been reviewed by the physician and that the physician had responded to those irregularities. This deficient practice was evident for 2 (Residents #2 and #5) of 5 residents reviewed for Medication Regimen Review during the facility's recertification survey. The findings include: 1) On 07/23/2026 at 11:27 AM, a review of the consulting pharmacist's Monthly Medication Regimen Review (MRR) tracking for Resident #2 identified pharmacist reviews completed monthly. The tracking indicated irregularities were identified on 08/28/2025, 12/26/2025, 03/26/2026 and 05/18/2026. Copies of the reports documenting those irregularities were requested for review. On 07/23/2026 at 11:32 AM, review of the electronic medical record for Resident #2 identified a pharmacy review progress note dated 05/18/2026 stating, Pharmacy order reviewed. See report for any noted irregularities and/or recommendations. The progress note also documented an order was obtained for continuation of PRN lorazepam beyond 14 days due to the resident's limited life expectancy. Review of a pharmacy review progress note dated 08/28/2025 stated, Pharmacy order reviewed. See report for any noted irregularities and/or recommendations, and documented a recommendation to request a psychiatric consultation to assess progress and gradual dose reduction (GDR). On 07/24/2026 at 9:09 AM, the facility was unable to provide the separate written consultant pharmacist reports for the medication regimen reviews dated 05/18/2026 and 08/28/2025 that identified the irregularities referenced in the pharmacist's progress notes. Therefore, the specific irregularities and recommendations documented by the consultant pharmacist could not be verified. On 07/24/2026 at 1:24 PM, during an interview, the consultant pharmacist stated he completed monthly medication regimen reviews and documented identified irregularities in the electronic health record. He stated he did not always prepare a written report for the attending physician and sometimes contacted the physician directly by telephone, obtained orders, and documented the outcome in the electronic health record. On 07/24/2026 at 1:26 PM, a review of the facility policy titled Medication Regimen Review indicated the consultant pharmacist was to prepare a written report of all identified irregularities and recommendations for the Director of Nursing and Medical Director. The policy further stated that written reports, as applicable, were to be provided to the attending physician or prescriber for review and response, and that physician responses or other actions could be documented either on the written report or within the electronic health record. On 07/27/2026 at 1:56 PM, the Director of Nursing was asked to provide the separate written reports (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	submitted to the attending physician identifying the resident's name, relevant medication, and identified irregularity, as well as documentation that the attending physician reviewed the identified irregularities and documented any action taken or rationale for not accepting the recommendation. The Director of Nursing stated the facility did not have a separate written report and presented the consultant pharmacist's progress notes instead. Review of the progress notes did not identify the specific medication irregularities or recommendations referenced by the consultant pharmacist and did not demonstrate physician documentation acknowledging review of the reported irregularities or documenting any action taken or rationale for not implementing recommendations. 2) On 07/27/2026 at 10:21 AM, the surveyor reviewed Monthly Medication Regimen Reviews for Resident #5 from February 2026 through July 2026 and it identified medication irregularities in February and March. The pharmacist recommendations and documentation of physician review and response were requested. On 07/27/2026 at 11:40 AM, the Director of Nursing (DON) provided the pharmacy recommendation related to the March medication irregularity and provided the pharmacist progress note related to the February identified irregularity. The DON stated that she was unable to provide documentation of the physician's response related to the February 2026 medication irregularity. Review of the pharmacist progress note dated 02/22/2026 revealed the pharmacist documented, Will request review for continued need and benefit from nystatin treatment and ketoconazole shampoo. When asked regarding the physician's decision related to the recommendation, the DON stated that she would look for the documentation. On 07/27/2026 at 1:28 PM, during an interview with the Medical Director, when asked about the process for pharmacy reviews and communication with physicians, he stated that there was a process in place to acknowledge that a recommendation had been made and that it was the physician's responsibility to agree or disagree with the recommendation. When informed of the inconsistency between pharmacist recommendations and available physician documentation of responses, the Medical Director acknowledged the concern and stated that there should be a process to ensure pharmacy recommendations and physician responses were completed and documented. He stated that he would investigate reasons for the inconsistencies and provide education to the physicians. On 07/27/2026 at 3:46 PM, the DON stated that she could not locate the physician's response for the February medication irregularity. The DON was informed that the inability to provide documentation of physician review and response was a concern.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interviews and medical record review, it was determined that the facility failed to ensure residents received routine dental services. This was evident for 1 (Resident #80) of 1 resident reviewed for dental services during the annual survey. The findings include: On 07/21/2026 at 1:05 PM, during an interview, Resident #80 stated that they had not seen a dentist since being admitted to the facility. On 07/22/2026 at 12:12 PM, a review of the medical record revealed that Resident #80 was admitted to the facility in August 2024. The record showed the resident was scheduled for a dental appointment in November 2024, but refused the visit. Further review of the medical record revealed no subsequent dental appointments had been scheduled or completed following the refusal. On 07/23/2026 at 9:04 AM, the Assistant Director of Nursing (ADON) was interviewed. She confirmed Resident #80 was scheduled for a dental appointment in November 2024 but refused the visit. She stated that after the refusal, the resident was not placed back on the dental provider's schedule and had not been offered another routine dental appointment. The ADON confirmed the resident had not been seen by a dentist since admission. She stated that, following survey intervention, the facility would schedule the resident for a dental appointment. On 07/23/2026 at 10:36 AM, the Director of Nursing (DON) was interviewed. When asked whether Resident #80 had been offered or seen by a dentist during 2025 or 2026 prior to survey intervention, she stated, No. After the resident refused in 2024, it was never offered again. She further stated that the facility was working with the dental provider to ensure residents are routinely seen or offered dental services.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that the facility failed to: (1) maintain accurate and complete documentation related to residents' advance directives; and (2) ensure the accuracy of residents' medical records. This deficient practice was evident for 2 (Residents #245 and #319) of 2 residents reviewed for advance directives during the facility's recertification survey. The findings include: A MOLST, or Medical Orders for Life-Sustaining Treatment, is a portable medical form that translates a seriously ill person's choices about CPR, intubation, and other care into real medical orders. An HCA/POA (Health Care Agent / Power of Attorney) is a legal document and designated person that allows a trusted individual to make medical choices for someone if they become unable to speak or decide for themselves. 1) On [DATE] at 8:50 AM, a review of Resident #245's electronic health records was completed. The resident had 2 separate active MOLST forms were identified to have 2 different code statuses. The MOLST form from [DATE] was marked as Full Code and the form from [DATE] was marked as No Cardiopulmonary Resuscitation (CPR) and do not intubate. On [DATE] at 12:20 PM, a review of Resident #245's paper chart was conducted. The 2 MOLST forms with different code statuses were in the chart in a red translucent folder. On [DATE] at 12:47 PM, an interview with Staff #23 was conducted. When asked where nursing staff can locate the MOLST form, Staff #23 stated in the electronic health record or in the paper chart. When asked which MOLST form the nursing staff use if there are multiple in the chart, Staff #23 stated the most recently completed form. On [DATE] at 8:40 AM, an interview with the Director of Nursing (DON) was conducted. The DON stated that their expectation is that the old MOLST form is voided and crossed out by the provider creating the new MOLST. The Old MOLST form is then placed in the back of the chart and the form is updated in the electronic health record to reflect that it has been voided. The Surveyor made DON aware of Resident #245 having multiple MOLST forms with different code statuses in both the paper chart and the electronic health record. The DON confirmed that Resident #245's old MOLST form should have been crossed out by the provider at the time the new MOLST was created. 2) On [DATE] at 8:51 AM, review of Resident #319's progress notes identified a social work note dated [DATE] documenting that the resident's active MOLST inaccurately indicated the resident had a health care agent/power of attorney. The note stated, SWK informed physician via email today that the resident's MOLST notes that resident has an HCA POA, but that the resident does not have one due to resident and son not completing the advanced directive paperwork. On [DATE] at 9:07 AM, review of the resident's active MOLST, completed in 2023, revealed the (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signature section identified the decision maker as either the patient or the patient's health care agent named in an advance directive. The MOLST also contained the statement in the Other Orders section, Based on conversation with patient's son (HCDM) . On [DATE] at 11:08 AM, Social Worker #14 was interviewed. She stated that part of her responsibilities included reviewing completed MOLST forms for accuracy and notifying physicians when corrections are needed. She stated that Resident #319 was capable of making their own medical decisions and did not have any completed advance directives. She acknowledged the MOLST incorrectly reflected that the resident had a health care decision maker and stated that a new MOLST should have been completed once the error was identified. During a follow-up interview on [DATE] at 11:37 AM, Social Worker #14 stated that she had reviewed the MOLST with the resident during care plan meetings and that the resident agreed with the treatment preferences documented on the form. However, she again confirmed the resident did not have an advance directive or designated health care decision maker and acknowledged the active MOLST was not completed correctly because it stated the orders were based on a conversation with the resident's son. Social Worker #14 confirmed the inaccurate MOLST should have been replaced with a corrected form after the error was identified.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of Complaint #3092378, and staff interviews, it was determined that the facility failed to maintain effective pest control measures to prevent and control rodent activity within the facility. This deficient practice was evident on 1 (Ground [NAME]) of 9 units observed during the facility's recertification survey. The findings include: On 07/27/2026 at 9:45 AM, while on the Ground [NAME] Unit of the facility, the surveyor observed a mouse emerge from room SMK089 and enter a closed storage room through a gap beneath the door. The surveyor immediately notified Licensed Practical Nurse (LPN #24) and the Unit Manager, who were present with the surveyor at the time of the observation. Both LPN #24 and the Unit Manager turned toward the area, observed the mouse, and confirmed the surveyor's observation. On 07/27/2026 at 12:44 PM, the surveyor reviewed Complaint #3092378, which alleged the presence of rodents within the facility. On 07/27/2026 at 12:48 PM, during an interview, the Unit Manager, stated that the adjacent room where the mouse entered was used to store transport wheelchairs, floor mats, heel floatation boots, and Geri chairs. When asked about possible contributing factors related to the rodent sighting, she stated that one of the residents in the room kept sugar and food crumbs in the room and that Housekeeping usually took time to clean the room. When asked what actions were taken when a rodent was observed, she stated that nursing staff notified Environmental Services, who then contacted the pest control company. The Unit manager informed the surveyor that Environmental Services had been notified of the mouse sighting after the observation was made. On 07/27/2026 at 1:09 PM, during an interview, the Environmental Services (EVS) Supervisor (Staff #25) stated that a rodent had been sighted on the second floor on 07/22/2026. Staff #25 further stated that she had also been informed of the mouse sighting on 07/27/2026 and had not yet printed the email notification. When asked whether the facility had received complaints regarding rodents, Staff #25 stated that they received such complaints frequently. On 07/27/2026 at 1:17 PM, the Director of Environmental Services joined the interview and stated that the pest control contractor had already responded after receiving a work order regarding the mouse sighting. He further stated that an opening used as the rodent's point of entry had been identified and that the Maintenance Department was addressing the issue. On 07/27/2026 at 1:18 PM, the concern was discussed with the Nursing Home Administrator (NHA), who stated that she had been notified of the rodent sighting.		