

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2025
NAME OF PROVIDER OR SUPPLIER Marley Neck Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7575 East Howard Road Glen Burnie, MD 21060	
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 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 interview, review of facility-reported incident investigation and record review, it was determined that the facility failed to thoroughly investigate an incident. This was evident for 1 (Resident #59) of 3 residents reviewed for abuse during the recertification survey.</p> <p>The findings include:</p> <p>A Hoyer lift, also known as a patient lift, is a mechanical device used to safely lift and transfer individuals who are unable to move themselves, often due to mobility limitations.</p> <p>On 6/16/25 at 11:11 AM, in an interview with Resident #59, he/she stated that a Geriatric Nurse Assistant (GNA) was rough when he/she was transferred from wheelchair to bed. He/she added that he/she was supposed to be transferred via Hoyer lift, however, the GNA picked him/her up from my wheelchair and transferred him/her manually to the bed.</p> <p>On 6/27/2025 at 8:09 AM, a review of facility-reported incident MD00211974 revealed that on 11/19/24 at 6:00 PM, Resident #59 was transferred by GNA #10 from the wheelchair to the bed without using a lift. The allegation was confirmed with a statement provided by Resident #53.</p> <p>Further review of the facility's investigation revealed that the facility obtained statements from the staff and witnesses, however, the facility indicated, there were no interviews with other residents. The facility's findings also stated, failure to honor the resident's request for Hoyer lift was substantiated.</p> <p>On 6/27/25 at 10:35 AM, a review of Resident #59's medical records indicated a BIMS score of 13 of 15, cognitively intact (Brief Interview for Mental Status, BIMS, is a screening tool used to assess basic cognitive function in patients in long-term care facilities.)</p> <p>On 6/27/25 at 12:45 PM, in interview with the NHA, she stated that once the facility received a report of an incident from a resident/ family or staff, the facility immediately started the investigation. She added that the facility obtained statements from the victim, perpetrator, witnesses, staff and added that she expected that other residents who were under the care of the alleged perpetrator would be interviewed by the facility.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 215138
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on record reviews and facility staff interviews it was determined that the facility failed to ensure a Resident was provided scheduled showers. This was found to be evident for 1 (Resident #77) out of 1 Resident reviewed for Activities of Daily Living (ADL) during the re-certification survey.</p> <p>The findings include:</p> <p>According to the National Institute of Health (NIH) Activities of Daily Living (ADL) are basic routine tasks that most healthy individuals can perform without assistance. These activities include personal care tasks such as eating, dressing, bathing, toileting, managing continence, and transferring (moving from 1 position to another). The ability to perform activities of daily living is an essential measure of an individual's functional status. The inability to perform basic activities of daily living may lead to unsafe conditions and a poor quality of life. The healthcare team should be aware of the importance of assessing activities of daily living in patients to help identify those who require assistance, whether for temporary rehabilitation or long-term care planning.</p> <p>On 6/30/25 at 6:06 AM a review of the complaint MD00218418 revealed a concern that Resident #77 did not receive routine showers.</p> <p>A review of Resident #77's ADL's Documentation Survey Reports V2 was conducted on 6/30/25 at 6:39 AM. The report showed that the Resident's scheduled shower days were Tuesdays and Fridays on the day shift.</p> <p>Further review of the reports showed that the Resident had 13 opportunities since admission to receive a shower: 5/16/25,05/20/25, 05/23/25, 05/27/25, 05/30/25, 06/03/25, 06/06/25, 06/10/25, 06/13/25, 06/17/25, 06/20/25, 06/24/25, and 06/27/25. However, the Resident received 7 showers during this period: 5/16/25, 05/20/25, 05/23/25, 05/27/25, 05/30/25, 06/20/25, and 06/24/25.</p> <p>During an interview conducted on 6/30/25 at 8:40 AM, Geriatric Nursing Assistant (GNA)#7 stated that she had provided care routinely for Resident #77 and stated that the Resident had been compliant with all care and had not refused showers when offered. The GNA further stated that she was unaware of a reason why the Resident had not received his/her showers as scheduled.</p> <p>During an interview conducted on 6/30/25 at 9:16 AM, this Surveyor discussed the concern that Resident #77 had not received showers as scheduled. The Nursing Home Administrator (NHA) stated she understood the concern and would speak with the Director of Nursing.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to 1. provide a Resident with safe transfer from chair to bed and 2. ensure a Resident was free from an accident. This was found to be evident for 2 (Residents #59 and #146) out of 3 Residents reviewed for accidents during the re-certification survey.</p> <p>The findings include:</p> <p>1. On 6/30/25 at 8:06 AM a review of the Facility Reported Incident (FRI) MD00178278 revealed a report of a fall to the Office of Health Care Quality (OHCQ). The report advised that Resident #146 complained that during incontinent care the Resident fell off the bed.</p> <p>During review of the investigation file conducted on 6/30/25 at 8:17 AM, this surveyor reviewed the statement from Geriatric Nursing Assistant (GNA)#8. In the statement the GNA reported that around 5 am on 5/18/22, while changing Resident #146, the Resident rolled toward me but was sliding off the bed. I quickly grabbed him/her upper body that was leaning toward the floor and guided the Resident to the floor. I was unable to get the Resident back on to the bed alone. I then covered him/her up and called the nurse for assistance.</p> <p>According to the Centers of Medicare and Medicaid Services (CMS) a Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.</p> <p>Care Area Assessments (CAAs) are part of this process and provide the foundation upon which a resident's individual care plan is formulated. MDS assessments are completed for all residents in certified nursing homes, regardless of source of payment for the individual resident.</p> <p>MDS assessments are required for residents on admission to the nursing facility, periodically, and on discharge. All assessments are completed within specific guidelines and time frames.</p> <p>Bed mobility indicates how a resident moves to and from a lying position, turns side to side, and positions body while in bed or alternate sleep furniture</p> <p>On 6/30/25 at 8:32 AM a review of Resident #146's MDS quarterly assessment dated [DATE] was conducted. The Care Area Assessment (CAA) for Functionality showed that the resident required extensive assistance with a 2-person assist for bed mobility.</p> <p>During an interview conducted on 6/30/25 at 8:42 AM, GNA # 7 stated that she refers to the nurse assigned to the resident to understand the level of care a resident needed which included how many people are needed to provide care and transfer the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on 6/30/25 at 11:00 AM, the Director of Nursing (DON) stated it is the expectation of the facility that if the Resident's bed mobility is a 2 person assist than there should be 2 staff assisting the Resident when turning on their side. This surveyor explained the concern for their being one staff member when Resident#146 rolled to one side and fell off the bed. The DON stated that she would review the investigation file and return to discuss.</p> <p>On 6/30/25 at 11:50 AM, the DON returned and stated that after reviewing Resident #146's medical record it was determined that GNA #8 did not follow protocol. The Resident required a 2 person assist for bed mobility therefore the GNA should have gotten a second staff member to assist in the care of the Resident.</p> <p>2. A Hoyer lift , also known as a patient lift, is a mechanical device used to safely lift and transfer individuals who are unable to move themselves, often due to mobility limitations.</p> <p>On 6/16/25 at 11:11 AM, in an interview with Resident #59, he/she stated that a Geriatric Nurse Assistant (GNA) was rough when he/she was transferred from wheelchair to bed. He/she added that he/she was supposed to be transferred via Hoyer lift, however, the GNA picked him/her up from my wheelchair and transferred him/her manually.</p> <p>On 6/27/2025 at 8:09 AM, a review of facility-reported incident MD00211974 revealed that on 11/19/24 at 6:00 PM, Resident #59 was transferred by GNA #10 from the wheelchair to the bed without using a lift. The allegation was confirmed with a statement provided by Resident #53. The reported indicated that the Nursing Home Administrator (NHA) interviewed GNA#10, and he/she admitted to seeing the green Hoyer pad in the wheelchair prior to transferring Resident #59 to the bed. He/she admitted not checking the care plan on how the resident should be transferred.</p> <p>Further review of the facility's investigation revealed this findings: failure to honor the resident's request for Hoyer lift was substantiated.</p> <p>On 6/27/25 at 10:35 AM, a review of Resident #59's medical records indicated a BIMS score of 13 of 15, cognitively intact (Brief Interview for Mental Status, BIMS, is a screening tool used to assess basic cognitive function in patients in long-term care facilities.) The care plan initiated on 6/2/24 had an intervention of Mechanical lift required with transfers.</p> <p>On 6/27/25 at 11:57 AM, in an interview with GNA#11, he/she confirmed that the nursing staff are expected to utilize 2- 3 staff when transferring the residents using a Hoyer lift.</p> <p>On 6/27/25 at 12:45 PM, the Nursing Home Administrator was notified of the concern.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on record review and interview, it was determined that the facility failed to implement nonpharmacological interventions of pain and ensure that pain medication was given consistent with the professional standards of practice. This was evident for 1 (Resident #59) of 3 residents reviewed for pain management during the recertification survey.</p> <p>The findings include:</p> <p>The medical abbreviation PRN stands for pro re nata, a Latin phrase that translates to as needed or as the situation arises.</p> <p>Nonpharmacological interventions are treatments that manage pain without the use of medication. These interventions may include but are not limited to massage, music therapy, aromatherapy, applying mild heat or cold packs and repositioning.</p> <p>Oxycodone is a strong painkiller from a group of medicines called opiates, or narcotics used to treat moderate to severe pain.</p> <p>Pain parameters are the specific aspects of pain that are evaluated during an interview to understand a person's pain experience.</p> <p>On 6/18/25 at 7:18 AM, a review of Resident #59's active Physician's orders revealed the following:</p> <ol style="list-style-type: none"> 1. Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 5 mg by mouth every 6 hours as needed for pain. 2. Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for Pain. 3. Pain level Q (every) shift (1-3 mild) (4-7 moderate) (8-10 severe) pain of 1-3 with no prn: contact practitioner, &gt;= 4 with no prn or prn non-effective or new onset pain: contact practitioner. Document nonpharmacological pain intervention prior to PRN pain medication administration every shift for Assessment. 4. Non-pharmacological interventions: <ol style="list-style-type: none"> 1. Repositioning 2. Distraction 3. Activity involvement 4. As needed for Assessment. <p>Further review of the medical record revealed a Care plan intervention which indicated Administer non-pharmacological interventions (repositioning, diversion activities, snacks and fluids, ice / heat, music therapy, relaxation techniques, imagery.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/25 at 1:18 PM, in an interview with Registered Nurse/Unit Manager (RN/UM #3) and Licensed Practical Nurse (LPN #1) with regards to the facility's pain management process, they described that when a resident complained of pain, the nurses were expected to assess the resident and ask for their pain level. They added that the facility used a pain scale from 0-10. They stated that prior to giving the PRN pain medication, they would verify the orders in the medical record and checked the options based on the residents' pain level. They revealed that the facility used Tylenol for mild pain and gave stronger pain medication for severe pain. They confirmed that the nurses utilized pain parameters set in the PRN order before administering pain medication, however, if the resident had 2 PRN pain medications without pain parameters in the order, they would use their nursing judgment to determine which pain medication was the best for the resident. They added that generally, the Physician would specify if the medication was for mild, moderate or severe pain. However, after verifying the PRN pain medications of Resident #59 with RN/UM #3, he/she agreed that medications had no pain parameters. RN/UM #3 attempted to show the surveyor where the nonpharmacological interventions were documented in the medical record, however, after he/she verified the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) she confirmed that there was no evidence that the interventions were documented. He/she stated she would inform the Director of Nursing (DON) of the issue.</p> <p>On 6/18/25 at 1:42 PM, in an interview with the DON, she stated that in pain management, the facility utilized nonpharmacological interventions for pain and if the interventions were not effective, the nurses were expected to administer the medication based on the resident's pain level. The DON added that the pain parameters should be part of the PRN pain medication orders. The surveyor reviewed the June MAR of Resident #59 with the DON which showed that PRN Oxycodone and Tylenol did not have any pain parameters in the orders. The surveyor also informed the DON that the Oxycodone was administered on 6/9/25 for a pain level of 2 and Tylenol was administered on 6/2/25 and 6/11/25 for a pain level of 4. The surveyor also showed the June TAR with the DON, which indicated that the nonpharmacological interventions were not documented by the nurses as ordered. The DON stated that she would look for any documentation to verify the concern.</p> <p>On 6/18/25 at 1:55 PM, a review of the facility's Pain Management policy approved on 3/28/25, indicated the following:</p> <ol style="list-style-type: none"> 1. The use of the appropriate Pain Management Scale for the resident's ability to express pain. 2. History of pain and treatment for the resident- To include non-pharmacological and pharmacological treatment and whatever or not each treatment has been effective. <p>On 6/20/25 at 8:34 AM, the DON confirmed that the nonpharmacological interventions for pain were not implemented, she stated that she notified the staff development and an in-service/education for the nurses will be conducted. The DON added that she discussed the PRN pain parameters concern with the attending Physicians, and they all agreed to include them in the PRN pain med orders.</p>		