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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215138	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Rehabilitation and Wellness Center	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)
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 review of an email and interviews it was determined that the facility staff failed to report an allegation of verbal abuse to the state agency. This deficient practice was evidenced in 1 (#4) of 2 allegations of abuse reviewed during the complaint survey.The findings include:On 03/11/26 at 4:01pm during an interview with Resident #4 the surveyor asked about the incident when the Geriatric Nursing Assistant's (GNA) were talking about them as if they were not present. The resident verbalized they sent an email to Administrator #1 and Director of Nursing (DON) #2 about the incident.On 03/12/26 at 11:14 am during an interview with Administrator #1 she verbalized Resident #4 emailed them about their concern, but she was out sick and DON #2 was at a hearing. Administrator #1 provided the surveyor a copy of the email. Resident #4 sent an email to Administrator #1 and DON #2 on 12/09/25 at 12:57 am reporting while GNA #16 and GNA #17 were providing care the night before, they were making comments about the resident. Administrator #1 verbalized they missed the email and did not address Resident #4's concerns.On 03/12/26 at 12:14 pm during an interview with DON#1, she verbalized Resident #4 usually sent an email or would call them to be changed. They were not aware the resident had an issue with the GNA's; they missed the email as she just came back from vacation and they report allegations of abuse immediately to the state within 2 hours. They also report allegations of abuse to the Ombudsman.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of email and interviews it was determined that the facility staff failed to investigate an allegation of verbal abuse. This deficient practice was evidenced in 1 (#4) of 2 allegations of abuse reviewed during the complaint survey.The findings include:On 03/11/26 at 4:01pm during an interview with Resident #4 the surveyor asked about the incident when the Geriatric Nursing Assistant's (GNA) who were talking about them as if they were not present. The resident verbalized an email was sent to Administrator #1 and Director of Nursing (DON) #2 about the incident.On 03/12/26 at 11:14 am during an interview with Administrator #1 she verbalized Resident #4 emailed them about their concern, but she was out sick and DON #2 was at a hearing. Administrator #1 provided the surveyor a copy of the email. Resident #4 sent an email to Administrator #1 and DON #2 on 12/09/25 at 12:57AM reporting while GNA #16 and GNA #17 were providing care the night before, they were making comments about the resident. Administrator #1 verbalized they missed the email and did not address Resident #4's concerns.On 03/12/26 at 12:14 pm during an interview with DON#1, she verbalized Resident #4 usually sent an email or call them to be changed. They were not aware the resident had an issue with the GNA's; they missed the email.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on medical record review and interviews it was determined that the facility staff failed to document a resident's pain score after administering pain medication and failed to administer oxygen therapy and report to the provider a resident's oxygen saturation decreased to 86%-87%. This deficient practice was evidenced in 1 (#3) of 5 resident records reviewed during the complaint survey.The findings are:1. On 03/10/26 at 9:06 am a review of Resident #3 medication administration record (MAR) the resident was prescribed Methadone 10 mg PO (by mouth) BID (twice a day) for pain and Oxycodone 10 mg q (every) 8 hours PRN (as needed) for pain. On 02/06 @7:33 am Licensed Practical Nurse # documented they administered Oxycodone 10 mg PO to the resident. Resident #3 pain score was documented as 6. When the surveyor checked the electronic health record (EHR) there was no documentation to verify the pain medication was effective.On 03/10/26 at 11:14 am during an interview with Licensed Practical Nurse (LPN) #18 the surveyor asked when pain medication is administered to a resident does the nurse assess if the medication is effective. LPN #18 verbalized when they administer pain medication they assess the pain level prior to administration of the medication. They ask the resident if the medication was effective and document the follow up (F/U) pain score in PC. The F/U is done 30 minutes to 1 hour after the medication had been administered. On 03/10/26 at 11:16 am during an interview with Director of Nursing (DON) #2 she verbalized routine and PRN pain medication pain score should be documented. Prior to the administration of PRN medication, nurses should attempt non-pharmalogical techniques first. The F/U pain score is documented in PCC15-30 minutes after the medication is given. If the medication is not effective they have to call the provider and ask for another option. On 03/10/26 at 1:33 pm a review of the EHR revealed LPN #20 documented Resident #3 F/U pain score although LPN #19 administered the medication and was working on the unit. LPN #20 worked the night before. During an interview with DON #2 the surveyor asked why LPN #20 documented for LPN #19 when LPN was working. DON #2 was unable to answer the surveyor's question. The surveyor was unable to reach LPN #19 for an interview. 2. On 03/10/26 at 3:20 pm the surveyor reviewed Resident #3 change in condition and the CRISP report which revealed while the resident was in distress their oxygen saturation was 86%-87% but Resident #3 was not administered oxygen; DON #2 was made aware of the surveyor's findings. On 03/17/26 at 9:46 am during an interview with DON #2 she verbalized if there is a significant change in the residents' condition Monday -Friday, the inhouse Nurse Practitioner (NP) would assess the resident. During off hours they will notify the on-call provider; the provider would give recommendations. Even though the nurse reached out to the provider they didn't realize Resident #3 oxygen saturation decreased. DON #2 verbalized administering oxygen is a nursing judgment; the nurse dropped the ball.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation and interviews it was determined that the facility staff provided a resident with a wheelchair without assessing if the wheelchair was safe for use. This deficient practice was evidenced in 2 (#4 & #8) of 2 residents reviewed for having necessary equipment.The findings include: 1. On 03/11/26 at 5:20 pm a review of a Concern Form dated 02/06/26 revealed Resident #4 requested footrests for their wheelchair. There was a note indicating Rehab Director #12 had difficulty finding footrests for Resident #4's wheelchair because of the size of the wheelchair.On 03/12/26 at 12:01pm during an interview with Rehab Director #12 the surveyor asked did they ensure the resident had leg rests on their wheelchair. Rehab Director #12 verbalized they are having difficulty finding the legs rests that fit the resident's wheelchair. The prongs were wider than the standards rest; they don't stay in place. They tried modifications to keep the pieces together. Rehab Director #12 advised Resident #4 legs were propped up on chairs when their legs got tired while receiving therapy, however there was no documentation to verify they were trying to get the footrests for the wheelchair. They were just looking on Google to see if they could find them and did not reach out to a supply company.2. On 03/17/26 at 9:28 am while speaking with Resident #8 they verbalized their wheelchair did not lock and the arm rest would not lock. The resident verbalized feeling unsafe when they transferred from the wheelchair to the commode.On 03/17/26 at 11:23 am during an interview with Rehab Director #12 the surveyor asked if equipment is assessed for safety prior to giving the equipment to residents. Rehab Director #12 verbalized usually a wheelchair that has come to their department was from another resident. They turn them over quickly. Resident #8's arm rest that releases needed to be spun for the arm rest to work properly. The wheelchair was not assessed to be safe, it looked like the break was bent and they bent it back this morning.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews it was determined that the facility staff failed to ensure the dome food covers were dry before covering residents' plated food. This deficient practice was evidenced in 2 of 7 observations of the kitchen staff plating residents' food during the complaint survey.The findings are:On 03/10/26 at 8:18am during the modified kitchen tour the surveyor observed the kitchen staff preparing the residents' food. The surveyor observed Dietary Aide #5 place dome food covers with standing water over Resident #6 and Resident #7's plates. The surveyor requested Dietary Aide #5 to lift the dome food covers from the residents' trays and observed liquid in Resident #6's pureed food and liquid on Resident #7's bacon and on the plate. The surveyor observed wet dome shaped food lids stacked on top of each other near the tray line. Certified Dietary Manager #4 removed the plates from the tray line.On 03/17/26 at 10:02 am during an interview with Dietary Aide #5, they verbalized they thought the lids were already dry because they were cleaned the night before. They were not aware the lids needed to be dry before using as the kitchen staff just started using the racks.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview it was determined that the facility failed to maintain essential equipment in proper operating conditions. This was evident for 2 of 4 pieces of equipment assessed in the kitchen during the complaint survey.The findings include:All essential kitchen equipment must be maintained in safe operating condition in accordance with the manufacturer's specifications and remain accessible throughout kitchen operations.On 03/11/26 at 11:43 am the surveyor observed the kitchen staff preparing lunch trays. The last cart left the kitchen at 12:25 pm. The kitchen staff continued to prepare lunch trays that were unable to be placed in the cart due to the lack of space. The kitchen staff prepared a test tray for the surveyor.On 03/11/26 at 1:00 pm the surveyor tested temperatures of the food for a regular try. The temperatures wereHam 118.8 degrees FSweet potatoes 121.3 degrees FCollard greens 120.9 degrees [NAME] 03/17/26 at 10:51 am during an interview with Certified Dietary Manager #4 the surveyor voiced concerns about the temperatures of the food on the test try. CDM #4 verbalized they totally agreed that none of the temperatures were the proper temperature. An electrician was at the facility to repair the plate warmer and the pellet warmer. The plate warmer worked properly for about an hour. The pellet warmer was reading 135 degrees Fahrenheit initially, but when the staff pull it out for use, it would cool too fast.

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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. Based on observations and interviews it was determined that the facility staff failed to maintain a safe and sanitary environment for residents and staff. This deficient practice was evident based on observations in the kitchen during the complaint survey. The findings include:On 03/11/26 at 11:56 am while in the kitchen the surveyor observed different colored particles on the base of the food lid rack, copious black dust on the exhaust fan, and the front of the PTAC heat/air conditioner unit was detached from the unit. On 03/12/26 at 12:46 pm during an interview with Maintenance Director #13 the surveyor asked if there was a preventative maintenance schedule and the surveyor reported the maintenance issues observed in the kitchen. Maintenance Director #13 verbalized they have an app called TELS that the employees use to submit maintenance concerns. Sometimes it's word of mouth and the staff will tell them about issues. They have a monthly and a weekly schedule that's a part of TELS. Usually, the kitchen comes up every month. They inspect the dishwasher water temps, sometimes the kitchen staff would tell them if something is not working. Maintenance Director #13 stated when the kitchen was inspected on Monday, he did not notice the surveyor's concerns with the face of the P-Tech which was the AC/Heater that was falling. Everything in the kitchen goes out through that exhaust. He stated, the exhaust fan was usually cleaned about once a month. The kitchen staff was cleaning the tray table at one time, but maintenance will start cleaning it now. Usually, they would take the rack outside and power wash it.On 03/17/26 at 10:51 am during an interview with certified Dietary Manager #4 the surveyor asked when there are maintenance issues in the kitchen how they were reported. CDM #4 verbalized the staff are supposed to put maintenance issues in TELS, there is a computer in the office for the dietary staff to use. CDM #4 indicated they saw the issues but was focused on something else.