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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 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. The findings include: 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. 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. 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. 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. 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.) 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.

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, it was determined that the facility failed to accurately code the resident's discharge status on the Discharge MDS assessment. This was evident for 1 (Resident #88) of 3 residents reviewed for hospitalization during the recertification survey. The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, discharge assessments include the completion of a select number of MDS items in order to track residents when they enter or leave a facility. A Discharge Assessment-Return Not Anticipated (DCRNA) must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days while a Discharge On 6/20/25 at 7:20 AM, a review of Resident #88's medical records indicated a discharge date of 3/25/2025 at 11:50 AM to an Assisted Living Facility (ALF). This was supported by a Nurses note, a Discharge summary visit notes by Nurse Practitioner (NP #9), a Social Services note and a Physician's order dated 3/25/2025 which indicated, Discharge to ALF. However, a review of Section A of the MDS Discharge Return Not Anticipated (DCRNA) assessment with an Assessment Reference Date (ARD) of 3/25/2025 revealed that the discharge status was incorrectly coded as Discharge Status- Short- term General hospital (acute hospital). On 6/20/25 at 9:08 AM, during an interview with the Social Worker (SW), she described that changes to the residents' discharge status were communicated to the Interdisciplinary Team (IDT) through a weekly meeting. She also verified that Resident #88 was discharged to an ALF in Severna Park. On 6/20/25 at 9:17 AM, in an interview with the Minimum Data Set (MDS) coordinator, she confirmed that Resident #88 was discharged to an ALF and acknowledged that the discharge assessment should have been coded as discharged to community/AL. On 6/20/25 at 12:58 PM, the Director of Nursing (DON) was notified of the concern.

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 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. Based on medical record reviews and facility staff interviews, it was determined that the facility failed to initiate care plans based on medication use. This was evident for 2 (Residents #4, #32) out of 36 residents reviewed for care plan implementation during a recertification survey process. The findings include: A care plan details the daily support an individual requires to maintain quality of life, including personal care, medication, meals, social interaction, and mobility assistance. It ensures coordinated care across caregivers and service providers. On 6/18/25 at 6:35 AM, a review of Resident #32's medical record revealed a physician order dated 3/21/25 for busPIRone HCl 5 mg oral tablet. The order directs staff to administer 1 tablet by mouth every 8 hours for treatment of anxiety. On 6/18/25 at 12:49 PM, further review of the medical record revealed that the facility failed to initiate a care plan related to antianxiety medication to reflect the plan of care for Resident #32. During an interview with the Director of Nursing (DON) on 6/18/25 at 1:49 PM regarding Care Plan Initiation Process, the DON stated that a care plan is initiated upon admission and is updated as needed. She explained that the MDS Coordinators, in collaboration with the interdisciplinary team, are responsible for updating the care plan when there is a change in the resident's condition. When asked who is responsible for initiating the care plan, the DON responded, Any of the nurses, especially the admission nurse, managers, and MDS Coordinators. She further noted that medication updates are handled by both the nursing staff and MDS Coordinators. The surveyor informed the DON on 6/18/25 at 1:55 PM of concerns related to Resident #32, whose care plan had not been initiated for antianxiety medication. The DON acknowledged the concern and stated, I will look into it, noting that the resident is frequently admitted and discharged from the facility. On 6/20/25 at 8:33 AM, the DON confirmed that no care plan had been initiated for the resident #32's antianxiety medication. The DON stated, I went ahead and initiated one. The surveyor brought the concern to her attention, and she acknowledged the oversight. On 6/20/25 at 12:10 PM,a review of the medical record revealed that the care plan addressing the Resident #32 's antianxiety medications was initiated on 6/18/25, following surveyor's intervention. On 6/20/25 at 12:36 PM, a review of Resident #4's medical record review revealed the physician orders for Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for DVT on 3/21/25. On 6/20/25 at 1:27 PM, the surveyor informed the DON that Resident #4 is currently receiving anticoagulant therapy; however, there is no care plan in place addressing this intervention. The DON confirmed that a care plan for anticoagulant therapy had not been initiated and acknowledged the concern. (continued on next page)

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/25 at 1:52 PM, further review of the medical record revealed that a care plan addressing Resident #4's anticoagulant medication was initiated on 6/20/25, following the surveyor's intervention.

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, it was determined that the facility failed to apply a preventative brace ordered for a resident. This was found to be evident for 1 (Resident #1) out of 1 resident reviewed for quality of care. The findings include: Foot drop is an inability to lift the front part of the foot and toes. This can be caused by nerve injuries, muscle disorders, brain or spinal cord disorders (such as stroke). If foot drop persists, the muscles that point the foot downward can become tight and lead to a contracture. A foot drop brace, is designed to support the ankle and foot. The brace extends from the calf, wraps around the ankle, and extends under the foot, often inside the shoe. It provides support and can help lift the foot, preventing it from dropping and allowing for a more normal gait. An Ankle-Foot Orthosis (AFO) is a brace worn on the lower leg to support the ankle and foot. It is commonly used to treat foot drop by holding the foot in a proper position to prevent dragging and improve walking safety. On 6/16/25 at 2:36 PM, during an interview with Resident #1, he/she expressed a concern that he/she was supposed to have a foot brace on his/her left foot. He/she reported that the last time the foot brace had been worn was about a month prior. The resident explained that the brace was used to help with his/her foot drop. On 6/16/25 at approximately 2:40 PM, an observation in Resident #1's room showed that he/she was not wearing his/her brace. On 6/25/25 at approximately 8:30 AM, this surveyor conducted an interview with the Rehab Director. During the interview, the surveyor inquired about the status of Resident #1 and his/her left foot brace. The Rehab Director explained that the Resident had been using the brace to help maintain proper foot alignment and prevent contracture; however, use of the brace had resulted in a wound. He stated that the anticipated plan involved consulting with the wound care nurse and obtaining his/her approval before proceeding with a new brace. When asked about the current plan for the Resident and the brace, he further explained that once the wound healed, the team would move forward with reintroducing the brace. When asked what type of wound it was, he responded that he believed it was an ankle wound. On 6/25/25 at 9:11 AM, a record review of Resident #1 ' s Task Treatment Administration Record (TAR) for June 2025 showed that he/she had an order for: Hard Brace to LT [left] Lower Leg on while at bedtime & off in morning - check skin with application & removal every day and evening shift every day and evening shift for CONTRACTURE PREVENTION Record review also showed that a new order had been placed on 06/24/2025: (continued on next page)

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hold off Hard Brace to LT [left] Lower Leg on while at bedtime & off in morning - check skin with application & removal every day and evening shift every day and evening shift for CONTRACTURE PREVENTION due to impaired skin integrity. On 6/25/25 at 9:30 AM, a record review of Resident #1 showed a care plan for the following: MR. [NAME] has an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Limited ROM [range of motion]/Mobility, Weakness, Hemiplegia, with an intervention of AFO [ankle foot orthoses] to left lower leg during bedtime hours. On 6/25/25 at 9:43 AM, a record review of Resident #1's records showed that there was no documentation indicating that he/she had a wound on his/her left ankle. There was no documentation of a change in condition, and no mention of the ankle wound was found in the wound care orders. On 6/25/25 at 10:08 AM, this surveyor conducted an interview along with an observation of Resident #1 in his/her room. He/she did not have a foot brace on at that time. It was observed that a brace was sitting in the corner of the room, and on the side of the brace it stated, Foot Drop Protection. A picture was taken of the brace at that time. On 6/25/25 at 10:15 AM, this surveyor conducted an interview with Licensed Practical Nurse (LPN) #5. During the interview, she was asked if she was aware whether the resident had a wound. She responded that she was aware of a sacral wound but was not aware of any other wounds. She reported that she did not know of any other wounds. At that time, this surveyor requested that LPN #5 go to Resident #1 ' s room. This surveyor then asked LPN #5 to check the resident ' s ankles for wounds. Together, the resident ' s ankles were observed, and no wounds were identified. His/her skin was clear, with no open areas noted. On 6/25/25 at 10:20 AM, during an interview, this surveyor asked Licensed Practical Nurse (LPN) #5 if she was aware of any orders for Resident #1 to utilize a foot brace. She explained that he/she was supposed to use compression stockings but was not aware of any braces or similar equipment ordered for the feet. At that time, the foot drop brace was still visible in the corner of the room. On 6/25/25 at 10:42 AM, an interview was conducted with the Administrator. This surveyor made the Administrator aware of the concern that Resident #1 had an order to wear a foot drop brace for contracture prevention, and that LPN #5 was not aware of this order. Based on observation and interview, it appeared that he/she had not worn the brace in some time. The Administrator confirmed understanding.

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to ensure that the medication error rate was not 5% or greater. This was evident for 2 (Resident #74 and #82) out of 6 residents observed for medication administration. 2 errors were discovered out of 38 opportunities. The findings include: According to the Centers for Medicare and Medicaid (CMS) the Medication error rate is determined by calculating the percentage of medication errors observed during a medication administration observation. The numerator in the ratio is the total number of errors that the survey team observes, both significant and non-significant. The denominator consists of the total number of observations or opportunities for errors and includes all the doses the survey team observed being administered plus the doses ordered but not administered. The equation for calculating a medication error rate is as follows: Medication Error Rate = Number of Errors Observed divided by the Opportunities for Errors (doses given plus doses ordered but not given) X 100. On 06/18/25 at 8:26 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 administered the following medication order in error to Resident #74: Med Pass Product (2 [NAME]) one time a day for nutritional supplement. Give 6 oz. The surveyor observed LPN #1 pour the Med Pass Product into a plastic cup. When asked how the quantity of medication was supposed to be measured, LPN #1 stated that she did not know. She explained that the plastic cup held approximately 240 milliliters (mL) but was unsure of the exact method for measuring the amount of Med Pass Product. LPN #1 proceeded to administer the full cup to Resident #74. This is a medication error, as 240 mL equals approximately 8 ounces-exceeding the prescribed dose of 6 ounces. On 06/18/25 at 9:29 AM, it was observed that LPN #1 also administered the incorrect dose of medication to Resident #82: Spiriva Respimat Inhalation Aerosol Solution 2.5mcg/act (Tiotropium Bromide Monohydrate). 2 puff inhale orally in the morning for COPD educate the resident to rinse mouth after use. The surveyor observed LPN #1 administer only one puff inhalation of the medication to Resident #82, instead of the prescribed two puffs. On 06/18/25 at approximately 9:40 AM, an interview was conducted with LPN #1. The medication errors were discussed, and she confirmed her understanding. She further explained that, in the future, she could measure the Med Pass Product using the plastic medication cups, which have ounce measurements marked on the side. LPN #1 also apologized for not administering two inhalations of Spiriva to Resident #82 as ordered. (continued on next page)

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/18/25 at 12:46 PM, a record review of the Medication Administration Record (MAR) for Resident #74 confirmed that the medication order for Med Pass Product was for 6 ounces. Additionally, the MAR for Resident #82 confirmed that the medication order for Spiriva required two puff inhalations, not one.

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews it was determined that the facility failed to store food in a manner that maintains professional standards of food service safety. This practice had the potential to affect all residents eating food prepared by the facility's kitchen. The findings include: During the initial tour of the main kitchen on 6/16/25 at 08:00 AM with the Certified Dietary Manager (CDM), the following items were found open, unlabeled, and undated. 1. Frozen Omelets were found in a clear plastic bag on a shelf in the freezer. The bag was open and not labeled or dated. 2. An opened container of Tajín seasoning was found on a shelf in the kitchen area. It was not labeled or dated. During an interview with the Certified Dietary Manager (CDM) on 6/16/25 at 9:00 AM, he stated that the items found unlabeled should have been dated after opening. On 6/16/25 at 9:05 AM, the CDM was made aware of the findings and acknowledged the concerns. An observation with the CDM and District Manager was conducted on 6/20/25 at 7:05 AM of a food cart for breakfast service in A Wing. This Surveyor, the CDM, and District Manager observed the staff began to pass the breakfast tray at 7:10 AM and completed the service at 7:18 AM. Following the last tray served the CDM, then began to take the temperature of the food on the test tray. The following food temperatures were recorded: Orange Juice - 49 degrees Fahrenheit Milk - 49 degrees Fahrenheit Oatmeal - 163.9 degrees Fahrenheit Sausage Patty - 139 degrees Fahrenheit Eggs Florentine Bake - 140 degrees Fahrenheit On 6/20/25 at 7:25 AM, the surveyor informed both the CDM and the District Manager of concerns regarding the temperatures of milk and orange juice. Both acknowledged the findings. On 6/20/25 at 7:28 AM, an observation was conducted in the A-Wing nutrition storage room with the Certified Dietary Manager (CDM). The following was noted: A sandwich in a Ziplock bag labeled with resident #243's name was observed in the refrigerator without a date. (continued on next page)

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/20/25 at 7:35AM, the surveyor inquired about the expectations for resident food storage. The CDM stated that items should be labeled with the residents' name and the date of placement. He further confirmed that, according to facility policy, food may be stored in the refrigerator for up to five days. The surveyor informed the CDM of the concern, and he acknowledged the finding. Review of facility Food Safe Handling for Food from Visitor Policy statement on 6/20/25 at 8:19AM revealed that label foods with the resident name and the current date. On 6/20/25 at 8:46 AM, the Surveyor made the CDM and the Administrator aware of the above concern and both acknowledged receipt. On 6/24/25 at 7:20 AM, an observation on B-Wing Breakfast Service with Administrator and CDM recorded the following food temperatures: Fried eggs: 136°F Hot Ham: 126°F Apple juice: 50.5°F These findings were confirmed on-site with both the Administrator and the Certified Dietary Manager (CDM). The surveyor informed them of the concerns regarding food safety and temperature compliance. Both individuals acknowledged receipt of the information. On 6/24/25 at 8:30 AM, the Policy Review of Health Services Group, Inc Policy for Food Storage: Cold Foods/Beverages and Hot Foods explicitly required that: Cold beverages and cold foods must be maintained at 41 degrees Fahrenheit or below to ensure proper temperature control and prevent bacterial growth. Hot foods must be held at 135 degrees Fahrenheit or above to maintain food safety and prevent the growth of harmful microorganisms.

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, it was determined that the facility failed to ensure that the staff followed infection control protocols. This was found to be evident during the review of (1) medication administration and (2) laundry services, it has the ability to affect all residents. The findings include: 1) On 6/18/25 at 9:09 AM, this surveyor observed Licensed Practical Nurse (LPN) #1 administering medications to residents. At that time, it was observed that LPN #1 did not perform hand hygiene before entering the room to administer medication to Resident #82 and Resident #60. On 6/18/25 at 9:43 AM, this surveyor also observed that LPN #1 did not wipe down the blood pressure cuff or the pulse oximeter probe between use on Resident #82 and Resident #60. On 6/18/25 at 9:59 AM, this surveyor conducted an interview with LPN #1 to discuss concerns regarding infection control practices during medication administration. It was explained that the surveyor observed a failure to perform hand hygiene before entering residents' rooms, as well as a failure to disinfect the blood pressure cuff and pulse oximeter before using them on another resident. LPN #1 acknowledged the concerns and confirmed understanding that these practices pose infection control risks. 2) On 6/23/25 at approximately 12:50 PM, prior to the initial tour, this surveyor conducted a brief walkthrough of the laundry area. It was observed that clothing, which appeared to belong to residents, was hanging on a rack located in a hallway. The hallway was dirty, placing the clothing at risk for contamination. On 6/23/25 at 12:59 PM, this surveyor began a brief tour of the laundry room. At that time, it was observed that the Account Manager was covering the clothing in the hallway with blankets. On 6/23/25 at 01:00 PM, this surveyor conducted an interview with the Account Manager and inquired about the clothing and its ownership. The Account Manager explained that the clothing was intended for residents as donations, in case some arrived without any personal clothing. On 6/23/25 at 01:03 PM, this surveyor completed an interview and observation with the Account Manager regarding the blankets placed over the clothing. It was explained to the Account Manager that earlier, at approximately 12:50 PM, the clothing had not been covered at all. The surveyor further explained the concern that, even with blankets placed on top, the clothing remained at risk for contamination because it was not fully covered. Multiple areas of the clothing remained exposed and visible. Pictures were taken at that time of the clothing hanging on the racks with the blankets placed on top. This was identified as an infection control concern, as the hallway where the clothing was stored-based on the laundry area tour-was not clean and posed a contamination risk to the clothing intended for resident donations. The Account Manager reported understanding of the concern and stated that the issue would be addressed immediately.

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	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marley Neck Health and Rehabilitation 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, it was determined the facility failed to ensure that the resident's bathroom call system was functioning properly. This evident for 1 of multiple rooms observed during the recertification survey. The findings include: On 6/24/25 at 1:02 PM, in an interview with Resident #47, he/she stated that she fell in the bathroom on 6/23/25. He/she added that he/she attempted to pull the bathroom call cord to alert the staff, however, he/she was unsuccessful. He/she described the the cord got stuck and was not functioning, so he/she started yelling and maneuvered themselves towards the switch and slid the on/off switch for the call bell to activate. During an observation, the surveyor noted that the bathroom call cord was attached to a switch on the wall; the cord was hanging approximately 2 inches from the floor and the switch was 40 inches from the floor. Also, the surveyor attempted to pull the cord to activate the switch and confirmed that the pull cord was not functioning. The surveyor had to slide the on/off switch for the bathroom call light to activate the light. On 6/24/25 at 1:21 PM, the surveyor requested Licensed Practical Nurse (LPN #4) to test the call device of Resident #47's bathroom. The nurse demonstrated to the surveyor that for the bathroom light to function, the resident would pull the cord to activate the call light, however, when he/she pulled the cord, it did not work, he/she had to slide the switch to activate the light. The surveyor requested the LPN #4 to test the bathroom call cords of rooms #40 and #41, and as soon as he/she pulled the cords, it activated the call light. On 6/24/25 at 1:30 PM, the surveyor informed the Nursing Home Administrator (NHA) about the concern and asked her to accompany the surveyor to Resident #47's bathroom to test the call device. She pulled the cord and confirmed that it was not working and stated that she would put up a maintenance request and conduct an audit of all the bathroom call devices. On 6/26/25 at 8:09 AM, the surveyor conducted a follow up observation of the call device in the of Resident #47, the pull cord was still not working. The observation was witnessed by another surveyor. On 6/25/25 at 10:27 AM, the surveyor received a copy of the Bathroom Call Light Audits from the Business Office Manager (BOM). A review of the audit which was completed by the Interdisciplinary Team (IDT) on 6/25/25 revealed the following: room [ROOM NUMBER]- 1- no battery (replaced), room [ROOM NUMBER]-1 no battery (replaced) , room [ROOM NUMBER]-2 no battery (replaced). On 6/25/25 at 11:16 AM, the surveyor notified the NHA and the Maintenance Director that the bathroom call device of Resident #47 was still not functioning. They confirmed that the device has been fixed.