STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215191	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mallard Bay Nursing and Rehab	520 Glenburn Avenue Cambridge, MD 21613

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and staff and resident interviews, it was determined that the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice. This was evident for 1 (Resident #59) out of 40 residents reviewed during the survey.The findings include: On 9/02/2025 at 8:52 AM, the surveyor began their initial observation of Resident #59 who was sleeping at this time. Later that day, around 1 PM, the surveyor returned and discussed in detail with Resident #59, their wound care and having maggots in their wound 2 times. The first time occurred about a week after he/she arrived at the facility. Resident #59 stated that it wasn't that many, I didn't even know they were there until the nurse was doing the dressing change. But the second time was last week, and there were more; I could feel them moving around. Resident #59 was asked if this was reported. Their reply was, Yes, there was a nurse and the unit manager. On 9/04/2025 at 10:20 AM, the surveyor spoke with the Unit Manager #3 for Unit 3, who was also the ADON, and asked her if she was aware that Resident #59 had maggots in their wound. She stated that she was informed. Then she was asked if she had any documentation in reference to this happening. The Unit Manager #3 stated that she would look into it and get back with the surveyor. On 9/04/2025 at 10:35 AM, the surveyor spoke with the DON #2 and asked if she was aware of a resident having maggots in their wound and if she had any documentation for it. DON #2 stated that she would have to follow up with the surveyor regarding this matter. During record review on 9/4/25, the surveyor was unable to locate any documentation in progress notes that the incidents with wound care occurred, looking all the way back to when Resident #59 first arrived, to the present. Resident #59 had orders written on 7/30/25, which state to Cleanse with VASHE. Apply Xeroform to the base of the wound. Secure with ABD, Kerlix, and Ace bandage. Change daily and PRN. Please date and time dressing every day and night shift. When reviewing the Treatment Administration Record for August and September 2025, it revealed that the nurses were signing off every day and night shift that the dressing was being changed. On 9/4/25 at 1:03 PM, the facility failed to provide any documentation of when Resident #59 stated and showed that he/she had maggots in their wound on the 2 occasions. The Unit Manager #3 stated that she was aware of the situation; however, she was unable to find any documentation of when the incidents occurred. On 9/04/2025 1:25 PM, the surveyor followed up with the DON #2 and the ADON #3 about their knowledge of Resident #59 having maggots in their wound and not having any documentation of the incidents. Both the DON #2 and the ADON #3 stated that there was no documentation, and they were unable to provide a reason or solution. On 9/04/2025 at 3:18 PM, during a wound dressing change for Resident #59, it was noted that the present dressing was dated and timed, 9/1/25 at 7:30 PM, and had been initialed (which was unreadable). The surveyor made the nurse doing the dressing change aware that it was the last change on 9/1/25. The nurse did not reply. There was a GNA (GNA #33) present to assist with the dressing change also witnessed the date and time of the dressing. On 9/5/2025 at 9:30 AM, the surveyor spoke with the ADON #3 and with the nurse (RN #21) who did the dressing change on 9/4/25, to inform her that the dressing was dated 9/1/25 at 7:30 PM as the last time the dressing had been changed, before RN #21 did the dressing change on 9/4/25. The ADON #3 stated that she understood.