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	10/22/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 maintain an environment free of physical restraints. This was evident for 1 (Resident #2) of 1 resident reviewed for restraint usage during a complaint survey. The findings include:Brief Interview for Mental Status Evaluation (BIMS) - comes from a quick test that looks at how well you think, learn and remember. Scores range from 0 to 15. Lower scores can point to difficulties with memory or thinking (cognitive) skills. During a review of complaint #2639805 on 10/20/25 at 9:02 AM it was reported that Resident #2 was observed strapped to his/her wheelchair. During a medical record review 10/20/25 at 9:58 AM it was discovered that Resident #2 had a BIMS of 0 which indicated Severe Cognitive Impairment. A Nurse Practitioner Follow-Up Note from 10/14/25 reported, the patient is not able to sit still and had a diagnosis of severe dementia with agitation. During a review of the Care Plan for Resident #2 it was revealed that he/she was identified as an elopement risk/wanderer related to altered mental status, increased confusion and had impaired cognitive function/dementia or impaired thought processes related to disease process.During a review of copies of the facility reported incident investigation on 10/21/25 at 10:38 AM it was discovered to have several written Witness Statements which included:A written Witness Statement by Geriatric Nursing Assistant (GNA) #5 dated 10/13/25 reported she saw Resident #2 around dinner time and saw a gait belt wrapped around Resident #2's waist and chair. I then took pictures to show to Licensed Practical Nurse (LPN) #6 and the Director of Nursing (DON). She reported she asked Occupational Therapist (OT) #7 if there was an order for the Resident to have restraints and then assisted with passing out dinner trays. I was just waiting for for LPN #6 to get to work. I told LPN #8 and before I got to tell LPN #6 she had told her. GNA #5 continued, I went back to 200 unit removed the gait belt. I brought Resident #2 over 100 unit. A written Witness Statement by the Occupational Therapist #7 dated on 10/10/25 reported at approximately 6:30 PM on 10/09/25, GNA #5 expressed to me she saw Resident #2 had a gait belt around his/her waist and that it was buckled. She showed me photos and On the way out I observed the same. I was unable to find anyone on his/her unit. I recognize I should have removed the gait belt at that time in hind sight.A written Witness Statement by GNA #9 dated 10/10/25 reported, The gait belt was used to transfer Resident #2 into the chair right before lunch and we did remove the belt after transferring him/her into the chair. After we got him/her into the chair we took him/her next to the nurse's office. He/she kept trying to get up so I don't know what happened next because I got up to pass out dinner and ice water.A typed statement from Licensed Practical Nurse (LPN) #10 dated 10/14/25 reported that GNA #5 told her Resident #2 was observed alone and restrained in his/her wheelchair with a gait belt positioned around his torso and the chair and she showed me several photos on her phone depicting a patient's torso secured to a wheelchair, as well as additional images supporting what she had described. Later GNA #5 returned and reported she discovered that restraints are not a part of Resident #2's Care Plan. GNA #5 then stated she removed the gait belt from the patient.A typed statement from LPN #6 dated 10/11/25 reported that GNA #5 reported Resident #2 still had a gait belt on for a long period of time. GNA #5 had taken pictures of the incident and they waited for me to get here assuming I was still the supervisor, so I could address the situation. Immediately after hearing what was going on, I went to check on Resident #2 and the belt was gone. She stated that GNA #5 told her she removed the gait belt from Resident #2. I allowed GNA #5 to sit with Resident #2 on 100 unit, her assigned unit because she was available to do so and 200 unit was short aides. LPN # 6 noted she reported it to the [NAME] written Witness statement from the Director of Rehab reported she was notified via text message at 7:12 AM on 10/10/25 by OT #7 that she had seen something on the way out of the building and that ‘it was hidden under his shirt' with a picture of a gait belt around the patient's waist and wheelchair. She added During conversation with OT #7 she stated that the gait belt was hidden under the shirt when she pulled the shirt up.An e-mailed statement from LPN #8 dated 10/13/25 at 4:39 PM reported GNA #5 showed her a picture of Resident #2 with a gait belt while sitting in his wheelchair. During a review of the Facility Reported Incident folder on 10/22/25 at 6:02 AM two additional items were found. These two items included a text message sent at 7:12 AM from OT #7 that showed a picture of a Resident with a belt wrapped around the back of the chair and around the side of the resident. The text stated, Just to let you know, I saw this on my way out. It was 'hidden' under his shirt (Resident #2). The second item was an e-mail dated 10/10/25 at 11:08 AM from the [NAME] President of Clinical Services that stated, Importance: High and Based on the course of events last night, please start in-servicing staff (all

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on medical record reviews and interviews, it was determined the facility failed to review and revise the interdisciplinary care plans to reveal accurate interventions to meet the needs of the residents. This was evident for 1 (Residents # 1) of 1 resident reviewed during the complaint survey.The findings include:Resident #1 was readmitted to the facility in May 2025 with diagnoses which include Systemic Lupus Erythematosus and Rheumatoid ArthritisOn 10/20/25 at 12:01 PM the surveyor reviewed Resident #1's clinical record. The review revealed that the resident received intravenous antibiotics for infections on several occasions. The most recent were Vancomycin via a peripherally inserted central catheter (PICC) line for several days from June 2025 to October 2025, Daptomycin via PICC line from August 2025 to September 2025 and Amoxicillin -Pot Clavulanate by mouth in October 2025.Further review of the clinical record failed to reveal a Care Plan with interventions for antibiotic therapy and PICC line care while the resident was receiving treatment for infections. During an interview on 10/21/25 at 8:50 AM the Unit Manager LPN#3 reviewed Resident #1's care plans and confirmed the surveyor's findings. The Unit Manager stated that it was the practice of the facility to update the resident's care plan in keeping with the residents' condition and clinical treatments, but she did not give a reason as to why Reside#1's care plan was not updated.In an interview on 10/21/25 at 9:25 AM the Director of Nursing was informed of the surveyor's findings.

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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. Based on medical record reviews and interviews, it was determined that the facility failed to ensure medical records were complete and accurate. This was evident for 2 (Resident #3 and #1) of 4 residents reviewed for accurate medical record documentation during the complaint survey.The findings include: 1) During a medical record review on 10/20/25 at 11:19 AM it was revealed that Resident #3 had several medications documented in the Medication Administration Record (MAR) as not given and reported the reason not given as 9 = Other/See Progress Notes. During a review of the Progress notes it was discovered that there was no documentation for the reasons the medications were not administered. The following medications were documented with 9 = Other/See Progress Notes and had no documentation found in the progress notes. Atorvastatin on 9/28/25 Meloxicam on 9/27/25, 9/28/25, 9/29/25, 9/30/25, 10/01/25, 10/11/25 Metoprolol on 9/30/25 Risperdal on 9/30/25 ABH Gel on 9/27/25, 9/28/25, 9/29/25, 9/30/25, 10/01/25, 10/02/25, 10/03/25. 10/04/25, 10/05/25, 10/06/25, 10/10/25, 10/12/25 Divalproex on 9/28/25 and 9/30/25 Seroquel on 9/28/25 and 9/30/25 Trazadone 9/28/25, 9/29/25, 9/30/25 Sinemet 9/27/25, 9/28/25, 9/30/25 During an interview with Registered Nurse #1 on 10/21/25 at 8:26 AM she advised if a medication was signed off as not given with 9 = Other/See Progress Notes it would be expected for there to be documentation in the progress notes reporting why it was not administered. She added that when 9 = Other/See Progress Notes is documented it would usually would be something that you would have to notify the doctor for. She confirmed that there were not any notes written for Resident #3 explaining the reasons the medications were not administered. During an interview with the Director of Nursing on 10/21/25 at 11:33 AM she advised that if 9 = Other/See Progress Notes was checked after medications were not administered there should be documentation in the progress notes. She confirmed several dates were signed off as 9 = Other/See Progress Notes for Resident #3 and was not able to find any documentation in the progress notes for the reason the medications were not administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Documentation in Medical Record Policy on 10/22/25 at 11:25 AM it stated that Documentation shall be accurate, relevant and complete, containing sufficient details about the resident's care and/or responses to care. 2) A peripherally inserted central catheter (PICC) line is a thin, flexible tube that is inserted into a vein in the arm or neck and threaded into a large vein in the chest. A PICC line can be used for many types of intravenous treatments. On 10/20/25 at 12:01 PM a review of Resident #1's clinical record revealed that the resident was treated for infections with intravenous antibiotics through a PICC line. The record revealed that a PICC line was in place from 06/01/25 and continued to be in place until 10/17/25 when it was discontinued. Further review of the clinical record revealed a physician's order and a Treatment Administration Record (TAR) as follows: PICC Valved: Flush with 10 Ml normal saline, infuse medication, then 10 Ml normal saline one time a day for PICC MAINTENCE FLUSH PRE AND POSTMED ADMIN -Start Date 06/01/2025 DC Date 10/20/2025. The TAR was signed by Licensed Nurses during the period the resident received antibiotic therapy to indicate that the PCC line was flushed. The TAR and physician's order failed to reveal the site/location of the PCC line. During an interview on 10/21/25 at 8:50 AM with the Unit Manager LPN# 3, the surveyor enquired as to where the PICC line was located. The Unit Manager reviewed Resident#1's clinical record and told the surveyor that she did not know because it was not stated on the physician's order or on the TAR. Unit Manager LPN #3 also stated that it was the practice for the site of the PICC line to be documented in the physician's order and on the TAR. During an interview on 10/21/25 at 9:25AM the Director of Nursing (DON) confirmed the surveyor's findings by reviewing the records. The DON stated, we do document the site but it is not documented on this record. On 10/22/25 at 7:37 AM the DON informed the surveyor that the Assistant Director of Nursing had completed an audit and PICC line orders were updated to include the location of the catheter site.