STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on medical record review, observation, and interview, it was determined the facility failed to ensure that the resident's call light was within reach, per the individualized care plans, to allow access to assistance when needed. This was evident for 2 (#1, #6) of 10 residents reviewed during a complaint survey.The findings include:1) On 1/6/26 at 10:02 AM Resident #1's medical record was reviewed and revealed Resident #1 was admitted in October 2025 with diagnoses that included a cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.Review of Resident #1's care plan, has an ADL (activities of daily living) self-care performance deficit r/t impaired mobility, disease process, advanced age, dementia, activity intolerance, and left hemiplegia had the intervention, encourage the resident to use call bell for assistance. A second care plan stated, has had an actual fall r/t impaired mobility, poor safety awareness, disease process, and impulsive with the intervention, encourage the resident to use the call bell when attempting to get OOB (out of bed).On 1/6/26 at 10:30 AM observation was made of Resident #1 lying in bed. Resident #1's call bell was observed hanging on the wall behind the bed draped over 3 sconce lights and the cord was behind the headboard. On 1/6/26 at 10:30 AM an interview was conducted with Resident #1. Resident #1 stated that he/she had frequent falls. The resident was asked how he/she called the nurse and Resident #1's response was, I call the nurse. When asked how he/she called the nurse, Resident #1 looked around and was looking for the call bell. Resident #1 then lifted his/her arms behind the bed and was able to grab the call bell cord, however the call bell cord was stuck behind the bed, and he/she could not access it. At that time Geriatric Nursing Assistant (GNA) #6 walked into the room and the surveyor informed her that Resident #1 could not access the call bell. GNA #6 grabbed the cord, and she said it was stuck under the bed. GNA #6 had to raise the head of the bed to release the call bell cord.On 1/6/26 at 1:10 PM the Director of Clinical Operations was informed of the finding.2) On 1/6/26 at 2:45 PM a review of Resident #6's medical record revealed Resident #6 had been a resident of the facility since 2017 and had diagnoses that included a non-displaced fracture of the right humerus, primary osteoarthritis, obsessive-compulsive disorder, unspecified dementia, and repeated falls. Resident 6's medical record was reviewed and revealed Resident #6 had a fall on 9/28/25 that resulted in a hematoma on the head with laceration. Review of a 10/23/25 nursing note documented that Resident #6 fell and sustained a right humerus fracture. Review of Resident #6's care plan, at risk for falling had the intervention, keep call light in reach at all times while in room. Resident #6 also had a care plan, had an actual fall with injury that had the intervention, educate resident to use call bell when getting OOB (out of bed). On 1/6/26 at 2:37 PM, 1/7/26 at 8:58 AM, and on 1/8/26 at 8:38 AM observation was made of Resident #6 lying in bed. The call bell was not within reach as it was wrapped around the back, bottom of the quarter side rail and was lying on the floor. The Director of Nursing (DON) was with the surveyor on 1/8/26 and observed the call bell and (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, that is not supposed to be on the floor. The DON was informed of the other 2 observations.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that facility staff failed to ensure that resident medical records remained private and confidential. This was evident for 1 of 3 nursing units observed during a complaint survey.The findings include: On 1/8/26 at 8:43 AM observation was made of Resident #10's electronic medical record displayed on an opened computer screen that was sitting on top of an unattended medication cart on the 200-nursing unit. Resident #2's medications were on display and an opportunity to look at additional information was available. The medication cart was sitting in the hallway outside of room [ROOM NUMBER]. On 1/8/26 at 8:45 AM Staff (LPN) #21 walked up the hall to the medication cart where the surveyor was standing. The surveyor informed Staff #21 of the finding. Staff #21 stated, I didn't mean to leave the computer screen open. On 1/8/26 at 8:46 AM the Director of Nursing (DON) was informed of the finding. The DON stated she would speak to Staff #21 about the concern.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility staff failed to document the details of a transfer of a resident (Resident #9). This was evident for 1 of 3 residents reviewed for transfers during a complaint survey.The findings include:Review of Resident #9's medical record on 1/7/26 revealed the Resident was admitted to the facility on [DATE] and transferred from the facility on 12/4/25 to another nursing facility.Further review of the Resident's medical record did not reveal the reason the Resident was transferred to another facility, notice given to the Resident and the Resident's representative in writing and a completed discharge summary for the Resident.Interview with the VP of Clinical Services on 1/7/26 at 1:17 PM confirmed the facility staff failed to document the details of Resident #9's transfer to another nursing facility on 12/4/25.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to 1) ensure Minimum Data Set (MDS) assessments were accurately coded and 2) complete a discharge assessment. This was evident for 5 (#1, #6, #2, #5, #7) of 10 residents reviewed for complaints during a complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1)On 1/6/26 at 10:02 AM a review of Resident #1's medical record was conducted and revealed Resident #1 had a fall on 10/28/25, 11/1/25, and 11/2/25. Review of Resident #1's admission MDS with an assessment reference date (ARD) of 11/3/25, Section J, falls, only captured 1 fall without injury. The facility failed to capture the other 2 falls. Further review of the MDS, Section J0100B, pain management, received PRN (when necessary) pain medicine, was coded no. Review of Resident #1's November 2025 Medication Administration Record (MAR) documented Resident #1 received Tylenol on 11/2/25. The facility failed to capture the PRN pain medication. On 1/7/26 at 10:15 AM an interview was conducted with the MDS Coordinator, Staff #3, who confirmed the errors. 2) On 1/6/26 at 2:45 PM a review of Resident #6's medical record was conducted and revealed on 10/23/25 at 8:11 AM Resident #6 had a fall inside his/her room and was found on the floor. Review of a 10/23/25 Nurse Practitioner note documented, reviewed x-ray of right extremity, which shows a mildly displaced fracture of the right humerus. Review of the MDS with an ARD of 11/21/25, Section J1900C, Number of falls since prior assessment, major injury was coded 0 none. Resident had a fractured humerus on 10/23/25 per the NP note. On 1/7/26 at 10:15 AM an interview was conducted with the MDS coordinator who confirmed the findings. 3) On 1/7/26 at 7:55 AM a review of Resident #2's medical record was conducted and revealed a 9/19/25 MDS assessment, Section J, that documented Resident #2 had a fall with a major injury within the lookback period. Review of a 9/14/25 health status note documented Resident #2 had a fall and landed on his/her right elbow. There was an order for an x-ray, however the resident refused the x-ray. Further review of the medical record revealed Resident #2 sustained a fracture of the right elbow on 7/16/25, however the fracture was not due to a fall. The resident fractured the right humerus while lifting a 5-pound weight. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS should not have coded a fall with major injury. On 1/7/25 at 1:14 PM an interview of MDS coordinator was conducted and she confirmed the error. 4)On 1/7/26 at 12:45 PM a review of Resident #5's medical record was conducted. A review of Resident #5's November 2025 MAR documented that the resident received a Tuberculin PPD injection on 11/3/25 at 9:43 AM. Review of the MDS assessment with an ARD of 11/6/25 failed to capture the injection in Section N0300, Medications. On 1/8/26 at 10:46 AM the MDS Coordinator confirmed the findings. 5. The facility staff failed to complete an MDS discharge assessment for Resident #7. Review of Resident #7's medical record on 1/6/26 revealed the Resident was admitted to the facility in May 2025 and discharged in November 2025. Review of Resident #7's MDS Assessments on 1/6/26 revealed the last one conducted by the facility staff was a Quarterly Assessment on 9/2/25. No further MDS assessments are in the medical record including a discharge assessment. Interview with the MDS Coordinator on 1/6/26 at 12:09 PM confirmed she should have completed an MDS discharge assessment on 11/6/25. After Surveyor intervention, the MDS Coordinator completed an MDS discharge assessment on 1/6/26 with an ARD date of 11/6/25. Interview with the VP of Clinical Services on 1/6/26 at 1:10 PM confirmed the facility staff failed to complete an MDS discharge assessment on 11/6/25 for Resident #7.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 medical record review and interview, it was determined the facility failed to ensure residents received treatment and care in accordance with professional standards of practice (Residents #1, #2 and #3). This was evident for 3 of 10 residents reviewed during a complaint survey.1.The facility staff failed to administer medications as ordered by the physician for Resident #3. A review of Resident #3's medical record was conducted on 1/6/26 for the Resident's complaints of not receiving medications as ordered in December 2025. Review of Resident #3's November and December 2025 Medication Administration Records (MAR) revealed: On 11/28/25 the Resident was ordered Triamcinolone Acetonide Mouth/Throat Paste, apply to left lower side of gum topically after meals and at bedtime for mouth ulcer for 7 days. The Resident was not administered Triamcinolone Acetonide until 12/1/25. On 12/9/25 the Resident was ordered Triamcinolone Acetonide twice daily for 7 days. The Resident did not receive the medication on 12/9, 12/10 and 12/11/25 for the PM dose, 12/14, 12/15, 12/16, 12/19, 12/21 and 12/22/25 both AM and PM doses. On 12/9, 12/10 and 12/11/25 the Resident did not receive the PM doses of the following medications: 1) Carboxymethylcellulos Sodium eye drops 2) fish oil 3) health shake 4) Lactobacillus 5) Naprosyn and 6) Vitamin C. Interview with the VP of Clinical Services on 1/7/26 at 10:20 AM confirmed the Surveyor's findings. 2. The facility staff failed to properly perform complete neuro checks after unwitnessed falls for Resident #1. A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. On 1/6/26 at 10:02 AM Resident #1's medical record was reviewed and revealed Resident #1 was admitted in October 2025 with diagnoses that included a cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side. Review of Resident #1's medical record revealed Resident #1 had unwitnessed falls on 10/28/25, 11/2/25, 11/27/25, and 12/26/25. Review of the facility's 10/28/25 fall's investigation included a neuro check assessment form that documented neuro checks were to be done every 15 minutes times 1 hour, every 30 minutes times 1 hour, every hour times 4 hours, every 4 hours times 24 hours, and every shift until 72 hours had passed. Further review of the 10/28/25 fall's neuro check assessment form only had 2 neuro checks after the fall. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the 11/2/25 and 11/27/25 fall's investigations did not have any neuro assessments.

Review of the 12/26/25 fall's investigation only had 9 neuro checks after the fall. The facility did not do every 4-hour times 4 checks and only did every 4 hours times 2 and not for 24 hours and the facility failed to continue neuro checks up to 72 hours.

On 1/6/26 at 11:57 AM an interview was conducted with the Director of Nursing (DON) related to the neuro checks. The DON stated, the neuro checks are ordered by the physician so however they prefer them to be done is how we do them. What I know of how I would do them is every 15 minutes times 4, every 30 minutes times 2, every hour times 4, every 4 hours times 4 and then every shift for a total of 72 hours. The DON was asked if there was a policy for neuro check assessments.

Review of the Head Injury policy that was given to the surveyor by the DON documented, perform neuro checks as indicated or as specified by the physician. The policy was not specific how and how often the neuro checks should be done.

On 1/6/26 at 12:46 PM an interview was conducted with the facility's Medical Director (MD) who stated I expect neuros to be done. We say do neuro checks and it should be what the facility policy is. At that time the MD was informed of what the facility policy stated, perform neuro checks as indicated or as specified by the physician. The MD stated, I know that most doctors just say to perform the neuro checks. I will work with the facility to define that process.

3. The facility failed to order a Vitamin D supplement when the resident's Vitamin D level was low per the Nurse Practitioner (NP) findings:

On 1/6/26 at 10:02 AM Resident #1's medical record was reviewed and revealed a 11/3/25 nurse practitioner progress note that documented, review of labs shows patient with low Vitamin D levels. Start Vitamin D 5k (5,000) I U (international units) daily. Continue to monitor.

Review of a 11/12/25 nurse practitioner progress note documented that Resident #1 stated he/she felt sleepy. The note stated that the NP reviewed Resident #1's labs which showed a low Vitamin D level. The assessment and plan stated, Vitamin D deficiency – Will start Vitamin D 20,000 international units daily. Consider lab work if symptoms persist tomorrow, will reevaluate. The note was written by NP #8.

Review of NP #8's post-fall note written on 11/21/25 documented Vitamin D deficiency.

Review of the most recent lab results dated 11/3/25 documented the Vitamin D level as 23.50 which was insufficient.

Review of Resident #1's Medication Administration Records (MAR) for November 2025, December 2025, and January 2026 were void of Vitamin D.

On 1/6/26 at 12:36 PM an interview was conducted with NP #8. NP #8 was asked about the Vitamin D and who puts the order in the electronic system. NP #8 said it was either/or. Either I put the order in or the nurse does. NP #8 was informed that Resident #1 was not receiving Vitamin D per review of the MARs and that there was no physician's order for Vitamin D. NP #8 stated, I was initially shadowing (name of another NP), and I had only been here 2 weeks at that time and was still learning the system. NP #8 confirmed the order was never put into the system.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/6/26 at 12:46 PM the Medical Director was informed about the issue with the Vitamin D and stated that the resident should have been on Vitamin D and that the preferred level for Vitamin D was 75 or greater. 4. Continued review of Resident #1's medical record revealed a 12/1/25 NP note that documented Resident #1 was seen for reports of repeated falls, including the fall on 12/1/25. The NP wrote for orthostatic blood pressure measurements and to consider hypotension (low blood pressure) secondary to the use of a particular medication. Orthostatic blood pressure measurements check how the blood pressure and heart rate change when someone moves from lying down to sitting and then standing, identifying a sudden drop in blood pressure upon standing (orthostatic hypotension) that causes dizziness or fainting, a common sign of autonomic dysfunction or dehydration, especially in older adults. Review of the December 2025 MAR, Treatment Administration Record (TAR), vital sign section of the medical record, and nursing notes failed to produce documentation that the orthostatic blood pressures were obtained. On 1/6/26 at 1:10 PM an interview was conducted with the Director of Clinical Operations regarding the orthostatic blood pressures. She stated she would look for them. On 1/6/26 at 4:00 PM she confirmed the findings that there were no orthostatic blood pressures performed. 5. On 1/7/26 at 7:55 AM a review of Resident #2's medical record was conducted and revealed on 10/22/25 the resident had a fall and sustained a right hip fracture. Resident #2 was sent to the hospital. Review of the hospital Discharge summary dated [DATE] documented that Resident #2 had an open reduction internal fixation of the hip on 10/24/25 for a right femoral neck fracture and was to make an appointment as soon as possible for a visit in 1 week. The resident was not seen until 12/9/25. Cross Reference F840. Review of a wound assessment dated [DATE] documented the surgical wound had staples and a wound assessment dated [DATE] documented the surgical site was resolved. There was no documentation found in the medical record of when the staples were removed. Review of Nurse Practitioner (NP) #8 notes dated 12/2/25 to 1/6/26 documented under the skin assessment that the staples were clean, dry, and intact. This was inaccurate as the staples were removed sometime between 11/11/25 and 11/24/25. Cross reference F842 On 1/7/26 at 11:36 AM an interview was conducted with the VP of Operations regarding the removal of staples. The surveyor asked if 30 days post-op was appropriate to wait for staples to be removed. The VP of Operations stated that she agreed that it was not appropriate and that 10 days post-op was the norm for staples to be removed. The VP of Operations was informed that it could not be determined when the staples were removed. There were no physicians' orders to remove the staples and there was no assessment of the area after the staples were removed. The VP of Operations was also informed that NP #8's notes from 12/2/25 to 1/6/26 documented that Resident #2 still had the staples in that were clean, dry, and intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/26 at 1:14 PM the concern was discussed with the Medical Director. The findings include: 1.The facility staff failed to administer medications as ordered by the physician for Resident #3. A review of Resident #3's medical record was conducted on 1/6/26 for the Resident's complaints of not receiving medications as ordered in December 2025. Review of Resident #3's November and December 2025 Medication Administration Records (MAR) revealed: On 11/28/25 the Resident was ordered Triamcinolone Acetonide Mouth/Throat Paste, apply to left lower side of gum topically after meals and at bedtime for mouth ulcer for 7 days. The Resident was not administered Triamcinolone Acetonide until 12/1/25. On 12/9/25 the Resident was ordered Triamcinolone Acetonide twice daily for 7 days. The Resident did not receive the medication on 12/9, 12/10 and 12/11/25 for the PM dose, 12/14, 12/15, 12/16, 12/19, 12/21 and 12/22/25 both AM and PM doses. On 12/9, 12/10 and 12/11/25 the Resident did not receive the PM doses of the following medications: 1) Carboxymethylcellulos Sodium eye drops 2) fish oil 3) health shake 4) Lactobacillus 5) Naprosyn and 6) Vitamin C. Interview with the VP of Clinical Services on 1/7/26 at 10:20 AM confirmed the Surveyor's findings.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on record review and interview it was determined the facility failed to follow-up when the Nurse Practitioner documented that a resident needed glasses due to not being able to see properly. This was evident for 1 (Resident #1) of 10 residents reviewed during a complaint survey.The findings include:On 1/6/26 at 10:02 AM Resident #1's medical record was reviewed and revealed an 11/12/25 Nurse Practitioner (NP) note written by NP #8 that documented that Resident #1 told NP #8 that he/she could not see without his/her glasses, and his/her glasses were broken.A 11/13/25 health status note documented, staff continues to monitor for falls as a safety precaution. Has had several falls recently without injuries.A 11/21/25 at 12:45 PM note documented that Resident #1 was observed on the ground in the courtyard. Resident #1 was returned to his/her room and assessed where he/she complained of dizziness and blurred vision.A 11/21/25 at 21:08 (9:08 PM) note by NP #8 documented, per the nursing staff, the patient fell out of [his/her] wheelchair onto [his/her] face while in the courtyard. The note documented that the resident felt dizzy and his/her vision was not great and was poor at baseline. The note documented, [he/she] needs to wear glasses, but [he/she] does not have any glasses at [his/her] bedside.Further review of Resident #1's medical record failed to produce any documentation that the resident was seen and glasses were obtained.On 1/6/26 at 10:30 AM an interview was conducted with Resident #1 who stated that he/she did have frequent falls. Resident #1 was asked if his/her glasses had been replaced or found and the answer was, no. They said they would get around to it.On 1/6/26 at 10:35 AM RN #7 was asked about Resident #1's glasses and she said she did not know anything about the glasses. RN #7 stated she worked full time on the unit.On 1/6/26 at 10:39 AM an interview was conducted with NP #8. NP #8 stated that she was at the facility every day Tuesday through Friday. NP #8 was asked about Resident #1's glasses and she stated she told one of the nurses about them, but she could not remember who she told. NP #8 stated that Resident #1 needed the glasses and she confirmed that the note that she wrote in Resident #1's medical record also stated that the resident needed the glasses.On 1/6/26 at 12:46 PM an interview was conducted with the Medical Director (MD). The issue with the glasses was reviewed with him and the issue with Resident #1 complaining of dizziness and not being able to see and the resident's complaint of poor vision. The Medical Director stated that the glasses issue should have been followed up on, and he agreed with the surveyor's findings.

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	01/08/2026

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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, observation, and interview, it was determined the facility staff failed to ensure fall mats and the resident's call bell were properly in place for a resident with a history of falls. This was evident for 1 (#6) of 10 residents reviewed during a complaint survey.The findings include: On 1/6/26 at 2:45 PM a review of Resident #6's medical record revealed Resident #6 had been a resident of the facility since 2017 and had diagnoses that included a non-displaced fracture of the right humerus, primary osteoarthritis, obsessive-compulsive disorder, unspecified dementia, and repeated falls. Resident 6's medical record was reviewed and revealed Resident #6 had a fall on 9/28/25 that resulted in a hematoma on the head with laceration. Review of a 10/23/25 nursing note documented that Resident #6 fell and sustained a right humerus fracture. Review of a 11/20/25 health status note documented Resident #6 was discussed in risk management meeting related to falls and a perimeter mattress and fall mats would be implemented. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Review of Resident #6's care plan, at risk for falling had the intervention, keep call light in reach at all times while in room. Resident #6 also had a care plan, had an actual fall with injury that had the intervention, educate resident to use call bell when getting OOB (out of bed), and fall mats to bilateral side of bed as tolerated. On 1/6/26 at 2:37 PM, 1/7/26 at 8:58 AM, and on 1/8/26 at 8:38 AM observation was made of Resident #6 lying in bed. The call bell was not within reach as it was wrapped around the back, bottom of the quarter side rail and was lying on the floor. The Director of Nursing (DON) was with the surveyor on 1/8/26 and observed the call bell and stated, that is not supposed to be on the floor. The DON was informed of the previous 2 observations.On 1/7/26 at 8:58 AM, while in the resident's room, there were no fall mats on the floor next to the bed. There was 1 fall mat that was folded in half by the doorway. Resident #6 was in the bed by the window, not by the door. A second surveyor was with the surveyor during the observation. On 1/7/26 at 9:52 AM an interview was conducted with the Medical Director regarding the falls Resident #6 had been having. The Medical Director was informed of the call bell not being within reach and the fall mat not on the floor next to the bed.On 1/8/26 at 8:38 AM Resident #6's call bell was observed in the same position as the previous 2 days. The DON was with surveyor at the time of the observation.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility failed to provide respiratory services in accordance with professional standards of practice. This was evident for 1 (#5) of 10 residents reviewed during a complaint survey.The findings include: On 1/7/26 at 12:45 PM a review of Resident #5's medical record revealed the resident had been admitted to the facility in October 2025 from an acute care facility with diagnoses that included seizures, traumatic brain injury, and chronic pain with spinal cord stimulator. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.Review of Resident #5's admission MDS with an assessment reference date of 11/6/25 documented that Resident #5 received oxygen while a resident at the facility. Review of the nursing admission assessment dated [DATE] documented that the resident was admitted with oxygen. Review of Resident #5's October 2025, November 2025, December 2025, and January 2026 physician orders failed to produce a physician's order for oxygen. There was no documentation on Resident #5's Medication Treatment Record (MAR) or Treatment Administration Record (TAR) for those months that Resident #5 received oxygen. Review of the vital sign section of the medical record documented the use of oxygen on 11/1/25, 11/3/25, and 11/6/25. There were no nursing assessments in the medical record from 11/1/25 to 11/7/25 that documented oxygen usage or the assessment of the resident's respiratory status. Further review of Resident #5's medical record revealed skilled nursing assessments dated 11/8, 11/9, 11/11, 11/13, 11/15, 11/23, 11/24, 11/25, 11/29, 12/4, 12/6, 12/8, 12/9, 12/10, 12/11, 12/12, and 12/30/25 that did not mention the use of oxygen. Nursing skilled assessments dated 11/12/25, 11/20/25, and 12/3/25 documented the use of oxygen. It was unknown how many liters of oxygen the resident was on, when the oxygen tubing was to be changed, and if there was supposed to be humidification of the oxygen during administration. Review of Resident #5's care plans failed to produce a care plan for oxygen use. On 1/8/26 at 8:40 AM an interview was conducted with Resident #5 who stated he/she was on oxygen when first admitted but he/she did not need it anymore. On 1/8/26 at 8:42 AM an interview was conducted with RN #22. RN #22 was asked if Resident #5 was supposed to receive oxygen. RN #22 stated that Resident #5 was non-compliant with the oxygen and currently refusing the oxygen. RN #22 was asked if there was supposed to be a physician's order for oxygen use. RN #22 stated yes, and when asked where the physician's order was located for the oxygen, she could not find it. RN #22 stated she was getting ready to notify the Nurse Practitioner (NP) about the resident's non-compliance related to oxygen therapy. RN #22 confirmed there was nothing in the medical record about the oxygen use.On 1/8/26 at 9:39 AM the Director of Nursing (DON) and the VP of Operations were informed of the finding.On 1/8/26 at 10:00 AM an interview was conducted with the Medical Director regarding NP #8 not noting anything about Resident #5's oxygen usage in her comprehensive assessments. The Medical Director stated he would address that issue.

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

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff failed to obtain outside services for a resident per the hospital discharge summary in a timely manner. This was evident for 1 (#2) of 10 residents reviewed during a complaint survey.The findings include: On 1/7/26 at 7:55 AM a review of Resident #2's medical record revealed Resident #2 was admitted to the facility in June 2025 and was readmitted to the facility on [DATE] following a hospitalization for a repair of a fracture of the right femur. Review of Resident #2's hospital Discharge summary dated [DATE] documented on 10/24/25 the resident had an open reduction internal fixation of the hip for a right femoral neck fracture and was to schedule an appointment as soon as possible for a visit in 1 week. Further review of the medical record revealed Resident #2 was not seen by the orthopedic doctor until 12/9/25. On 1/7/25 at 11:36 AM an interview was conducted with the VP of Clinical Services, Staff #10. Staff #10 confirmed the facility staff failed to schedule an appointment for Resident #2 within 1 week of discharge to see the orthopedic physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 2 (#1, #2) of 10 residents reviewed during a complaint survey.The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.1)The facility staff failed to keep neuro checks after unwitnessed falls in Resident #1's medical record.A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. On 1/6/26 at 10:02 AM Resident #1's medical record was reviewed and revealed Resident #1 was admitted in October 2025 with diagnoses that included a cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side. Review of Resident #1's medical record revealed Resident #1 had unwitnessed falls on 10/28/25, 11/2/25, 11/27/25, and 12/26/25. There were no neuro assessments found in Resident #1's medical record. On 1/6/26 at 10:53 AM an interview was conducted with RN #7. RN #7 was asked where neuro assessments were kept. RN #7 stated they were either on a piece of paper that goes to the Interim Director of Nursing (DON)'s office or sometimes she will put them in the vital sign section of the medical record. RN #7 stated she was not sure of the process.On 1/6/26 at 11:05 AM an interview was conducted with the Interim DON who stated that the neuro assessments were kept with the fall's investigation file that was kept in the DON's office. When asked if the neuro assessments were part of the medical record the interim DON said she would have to ask the VP of Operations.On 1/6/26 at 11:57 AM a second interview of the interim DON revealed the neuro assessments were kept with the fall's packet investigation in the office. The Interim DON confirmed they were not kept as part of the medical record. The surveyor asked her if it was the weekend and the physician wanted to see the neuro assessments that they would not be accessible in the medical record, that they would be in an office. The Interim DON confirmed. On 1/6/26 at 12:46 PM the Medical Director was interviewed and stated, they should be part of the medical record, and I have never liked that information like that was kept in a separate office. 2)On 1/7/26 at 7:55 AM a review of Resident #2's medical record was conducted and revealed on 10/22/25 the resident had a fall and sustained a right hip fracture. Resident #2 was sent to the hospital.Review of the hospital Discharge summary dated [DATE] documented that Resident #2 had an open reduction internal fixation of the hip on 20/24 for a right femoral neck fracture.Review of a wound assessment dated [DATE] documented the surgical wound had staples and a wound assessment dated [DATE] documented the surgical site was resolved. There was no documentation found in the medical record of when the staples were removed.Review of Nurse Practitioner (NP) #8 notes dated 12/2/25 to 1/6/26 documented under the skin assessment that the staples were clean, dry, and intact. This was inaccurate as the staples were removed sometime between 11/11/25 and 11/24/25. On 1/7/26 at 11:36 AM the concern was discussed with the VP of Operations who confirmed the findings.On 1/8/26 at 1:14 PM the concern was discussed with the Medical Director.