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	03/30/2026

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

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, it was determined that the facility staff failed to display the results of the annual recertification survey and plan of correction in a place readily accessible to residents, family members, and legal representatives. This was evident in the 1 of 1 survey results book posted in the facility. The findings include:On 3/24/26 at 8:05 AM, an observation of the lobby revealed no evidence of the State inspection results in an open and readily accessible area for residents, staff, and visitors to review. A Sign was not posted telling residents where the state survey results were located.On 3/24/26 at 8:11 AM, an interview with the MDS coordinator revealed she/he is waiting for maintenance to open the Administrator's office to get the survey bookOn 3/24/26 at 8:52 Am the Director of Nursing presented the survey book to the surveyor. The Director of Nursing confirmed that the placement of the results of survey inspections was not in a place easily accessible to any person to be reviewed and failed to post the sign telling residents where the state survey results were located.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review and interview with facility staff, it was determined that the facility staff failed to thoroughly investigate allegations related to potential abuse and injuries of unknown origin. This was evident during the review of 2 of 8 facility reported incidents (Residents #3). The findings include:1. The surveyor reviewed the facility investigation for Resident #3 on 3/23/26 at 1:54 PM. Resident #3 had 2 separate allegations of abuse, on 2/5 or 2/6 and again on 2/8. The facility provided the investigation packets which contained interviews of staff who cared for or were scheduled the days of the allegations. Although both incidents were investigated with a focus on Resident #3, the facility investigation did not contain any other resident interviews inquiring about abusive or neglectful treatment from facility staff, specifically the staff that were working on the days the allegations of abuse from Resident #3 were reported. During interview with the DON and Corporate [NAME] President of Clinical Operations on 3/24/26 as to the concern that there was no type of interview or assessment done for the other residents on the unit to ensure that they too were safe from potential abuse. As of 3/30/26, no further documentation was provided to the survey team regarding these incidents and investigations. The overall concern that although the allegations were not validated, no other residents were interviewed if able or assessed for any signs and symptoms of injury was reviewed with the facility. 2. Resident #6 whose medical record was reviewed on 3/25/26 at 10:15 AM, revealed the facility's' identification of a bruise on 3/4/26 on the right eye. The facility documented a change in condition and awareness of a new bruise on Resident #6's right eye on 3/4/26 at 4:09 AM. According to the facility report and subsequent record review on 3/24/26 at 1:35 PM, Resident #6 had a brief interview for mental status (BIMS) of '99,' meaning that Resident #6 was unable to complete the interview and therefore report how the injury occurred. A review of the facility investigation revealed that they identified how the injury potentially occurred, however, there was no definitive resolution. Additionally, there were no other interviews of other residents on the unit related to concerns of abuse or assessments of residents for potential injuries of unknown origin for those unable to speak for themselves, as in the case for Resident #6.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on a complaint related to the oral status of residents with tracheostomies and percutaneous endoscopic gastrostomy (PEG) tubes, observations, interviews with residents and staff, it was determined that the facility failed to provide oral care to a resident that was dependent on staff for activities of daily living (ADL). This was evident during the review of a complaint for 1 of 3 (#23) residents related to quality of care. The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. Resident #14 was observed and interviewed on 3/24/26 at 11:09 AM. S/he was noted with a tracheostomy and a behavior of intermittently chewing on the comforter, towel or blanket nearby. This resident made good eye contact with the surveyor and so s/he was interviewed. S/he was noted with a thicker white substance in the mouth that had a thick sticky appearance. S/he was asked if the staff brush [residents] teeth. S/he nodded left to right. S/he then mouthed and stated that the staff ?need to.'Resident # 14, according to the 2/11/26 minimum data set, was dependent on staff for oral care. Resident # 23 was then observed in his/her room on 3/24/26 at 11:58 AM. Resident #23 was sitting propped up in bed and was able to respond to the surveyors' questions at this time only with smiles. This surveyor noted that the resident's mouth inside the lips had a thick clear white milky substance that was observed to be on the upper and lower teeth and his/her lips as s/he tried to open their mouth when they smiled. Resident #23 was asked about oral care and would just smile. The roommate asked this surveyor to look in the nightstand and although there was the presence of oral care supplies, at this time, Resident #23's teeth and mouth were not clean. Resident # 23, according to the 3/11/26 minimum data set, was dependent on staff for oral care.The following observations occurred on 3/25/26 with the facility DON, NHA and Corporate VP of clinical services:Secondly, at the request of Resident #14's family, we all started at his/her room. The family was concerned about the residents' status and wanted to be updated. This surveyor notified the family member of Resident #14 the purpose of the room visits and proceeded to assess Resident #14's mouth and reminded him/her of my visit to the room yesterday. Resident #14 did not recall my visit or the discussion. The observation of Resident #14's mouth and dentition on 3/25/26 did not show any significant concerns of build up or accumulation at this time. Resident #23 was observed next at 1:55 PM. S/he was observed in bed and was responsive to the surveyor and DON when we spoke to [resident] with smiles. However, when the resident attempted to smile you could visibly see the same thick clear milky substance between the lips and caking the teeth and would string between the teeth when the resident tried to open his/her mouth. The concern related to the lack of consistent oral care provided to residents that are dependent on staff for oral care was reviewed with the administration staff at this time in addition to the lack of oral care provided to a resident dependent on staff for activities of daily living was also reviewed at this time again during exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation during tour and interview with facility staff, it was determined that the facility staff failed to ensure that resident medications and supplies, including oxygen were maintained in a secure fashion. This was an observation on 2 occasions and 2 additional times after the implementation of education by the facility DON and occurred on 3 of 3 units.The findings include:On 3/23/26 at 10:50 AM an oxygen tank was observed sitting on the floor with no supporting device present. The oxygen tank was located to the left behind the bed of Resident #12 who resides on unit 1.RN #1 was notified of the observation and concern and immediately proceeded to get a tank holder and secure the oxygen tank.Tour of the facility on the 3rd unit on 3/25/26 at 7:31 AM noted a treatment cart with a Collagenase Santyl cream on top labeled for Resident #17. This surveyor observed 2 residents wheeling past in power wheelchairs and staff sitting at the nursing station. Staff RN #7 was notified of the observation and concern and upon looking at the cream stated that it was just delivered and whoever received it did not put it away, and she immediately put it away.The DON was notified of the observations when at approximately 8:10 AM on 3/25/26 and she stated she would put education in place immediately.While touring the facility on 3/25/26 at 1:53 PM with the DON, NHA and Corporate VP of Clinical Services, we all simultaneously observed an unattended and unlocked treatment cart upon arriving at the unit 2 nursing station. The Corporate VP immediately locked it.On 3/30/26 at 9:36 AM on the top of a treatment cart, Diclofenac gel for Resident #19 was found with multiple packs of dressings. At 9:38 AM the DON happened to walk past and was notified of the concerns and observations.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of a complaint related to a new admission diet, staff and resident interviews, and medical record review, it was determined that the facility failed to employ sufficient staff to ensure all residents with dietary concerns were met. This was evident during the review of 3 of 3 (Resident #16, #26, #27) residents related to complaints about diet. The findings include:On 3/25/26 at 10:30 AM, review of the complaint 2962212 regarding admission assessments, revealed Resident #16 was admitted to the facility over 2 weeks ago in addition to other comorbidities for diabetic management with an A1C level of 11.5%. (A1C measures average blood sugar levels over the past 2-3 months, normal levels are below 5.7%). A review at this time of the hospital discharge orders, included a recommendation for a carbohydrate-controlled diet. Further review, however, revealed that upon admission, Resident #16 was ordered a regular diet with no acknowledgement of the need for the carbohydrate-controlled diet until 3/17/26, 1 week after the resident's admission, when s/he asked for larger portions. This review also revealed that as of 3/25/26 the dietitian had yet to see or review the resident's medical record.On 3/25/26 at 1:15 PM the facility dietitian, staff # 16, was interviewed regarding her process for visiting and assessing new residents. She said that she only has 12 hours at this facility a week and therefore needs to prioritize who she sees. The priority list was clarified. She stated residents that are new admissions with tube feedings for example would be seen first. The concerns relating to Resident #16 were reviewed with staff #16, that s/he was here specifically for her assistance with diet and modifications. She stated that Resident #16 would not have been a priority to be seen, however, she stated Resident #16 should have been admitted on the recommended diet from the hospital. At this time, she reviewed Resident #16's weight and stated that it's stable. This surveyor reviewed that the resident has only had 1 weight since admission 2 weeks ago. She again stated that she must prioritize who she sees and it is also determined in the risk meetings if there is a resident that needs to be seen. Surveyor met with Resident #16 in his/her room on 3/25/26 at 1:55 PM. S/he stated that they were very frustrated with the meals. S/he was asked if they had seen a dietitian yet and they stated ?no.'Additionally, for a new admission and a resident admitted for diabetic monitoring for the first 2 weeks of admission, there was only 1 weight completed, although the physicians continued to document on their visits that the resident's weight was ?stable.'A review of other recently admitted residents revealed the additional following concerns:Resident #26 readmitted to the facility on [DATE] was last seen by the dietitian on 9/19/25 secondary to a significant weight loss of 6.4 lbs. over 30days, there was no documented follow up since then. A review of Resident #26's weights noted that s/he has continued to lose weight and was currently 22lbs. less than when reviewed by the dietitian in September. Resident #27, admitted to the facility at the end of February 2026 with diagnosis including severe protein-calorie malnutrition, a month ago, still has had no review by the facility dietitian as of 3/25/26. Additionally, according to the documented weights, Resident #27 has had a 14 lb. weight loss, since admission (2 weeks) which equates to a 7% significant weight loss, that has not been assessed by the facility dietitian. The overall concerns related to the failure of the dietitian to see all new admissions to the facility timely and revisit as needed with the appropriate and timely implementation of interventions as needed was reviewed with the DON on 3/25/26 at 2:42 PM. A meeting held with the facility medical director, NHA, DON and Corporate VP of Clinical Services at 3:30 PM on 3/25/26 to review the concerns related to the lack of dietitian coverage and inability to timely see all the admissions and other residents as their diagnosis and acuity determined was reviewed at this time.

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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 review, observation and interview with facility staff, it was determined that the facility staff failed to ensure that the residents' medical records were maintained and documentation was complete. This was evident for 3 of 22 (#2, #7 and #16) medical records reviewed during a complaint survey. The findings include:1. Review of the complaint and medical record for Resident #7 on 3/23/26 at 9:50 AM revealed concerns related to wound care. However, according to the medication administration record (MAR) for the specific dates reported the wound care and subsequent treatments were signed off. During a face-to-face meeting with Resident #7 and the facility DON on 3/25/26 at 11:15 AM s/he had continued complaints about wound care and staff not changing the bandages. This surveyor reviewed that the MAR was reviewed for the dates that s/he had complained about and that staff had signed off that they completed the tasks. Resident #7 then stated that it occurred again this past weekend. This surveyor stated they would review the MAR for the identified concerns. The DON also stated that she would speak to the staff as well. This surveyor then proceeded to exit the room and review the MAR for other dates of concern for wound care treatment. This review on 3/25/26 at 2:50 PM revealed missing sign off from staff for wound care on 3/18/26 and 3/23/26. There were also 3 days out of 24 where staff failed to sign off the application of A&D ointment on Resident 7's feet. These concerns were reviewed with the facility DON on 3/25/26 during the exit conference. 2. Review of the medical record for Resident #2 on 3/25/26 at 9:43 AM revealed that there was a new injury of unknown origin, a bruise on the residents' left hand. The assigned GNA let the nurse know, and according to the facility documentation a change in condition was initiated at 11:30 AM on 1/8/26. However, a pain evaluation was not initiated and completed until 9:11 PM. According to a brief interview for mental status (BIMS a standardized, 15-point assessment used in long-term care to screen cognitive function, typically assessing orientation, memory, and attention) completed 12/2025 for Resident #2, revealed that s/he had a score of ?00' showing severe cognitive impairment. Resident #2 could not tell how the injury occurred according to the investigation or verbalize pain using a standard pain score assessment. The concern that an official pain assessment was not completed for a cognitively impaired resident timely after the finding of an injury of unknown origin according to documentation was reviewed during exit on 3/25/26. 3. The medical record of Resident #16 was reviewed on 3/25/26 at 10:35 AM regarding complaints surrounding his/her admission process. Part of the complaint noted that the resident did not receive the admission PPD (purified protein derivative is a screening tool for tuberculosis (TB) infection) skin test. However, according to the medication administration record (MAR) although there was a ?9' on 3/18/26 for the administration meaning see nurses note, which there was none, for the read date on 3/20/26, staff documented ?negative,' even though the injection was not signed off as administered.This surveyor met with Resident #16 in his/her room on 3/25/26 at 1:55 PM. S/he stated that they never received the PPD injection.This surveyor then met with the DON and reviewed the concerns on 3/25/26 at 2:41 PM. She stated that the facility was out of the PPD solution so ?no' they would not have administered the PPD test to Resident #16 on 3/18/26 and they will do it now. The concern remained that staff proceeded to document ?negative' on a test that was not administered.

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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 observations and interviews and medical record review, it was determined that the facility failed to ensure infection control orders were followed and consistent throughout the facility. This was evident during the review of a complaint related to residents on transmission-based precautions.The findings include:Contact precautions involve full-time gown/glove use and resident isolation for acute, infectious, or draining infections, usually time limited.Enhanced Barrier Precautions (EBP) use gowns/gloves only for high-contact care (e.g., dressing, transfers) for residents with known MDRO (multi-drug-resistant organism) colonization, allowing room sharing and social participation. Resident #17 at 8:24 AM was observed in the room with physical therapy. There were no signs up identifying the need for any personal protective equipment (PPE), however, a foley catheter could be seen from the doorway.At 8:25 AM, Resident #18 was observed in bed. The facility nurse practitioner (NP) was in the room on her personal phone, with no PPE and the assigned GNA, staff #13 was currently repositioning the resident, pulling him/her up in bed and wearing only gloves. Staff RN #8 at this time, was at the doorway to the room preparing the residents' medications. There was a sign to the right of the door stating, ?contact precautions.' When GNA #13 exited the room, she was asked by this surveyor about the care she provided, who the sign belonged to, as it was a double occupancy room and how she cleaned her hands as they were not observed washed. The NP, RN and GNA all stated that Resident #18 was not on any contact precautions. GNA #13 proceeded to state that the signs were hanging at all the doors, and this resident was ?just wrong.' This surveyor stayed in the vicinity for another 6 minutes making notes and observations until GNA #13 returned to the room and turned the sign around at the room entrance showing that there was no one in the room with the requirement of staff to wear PPE.The identified concerns were reviewed with the DON on 3/30/26 at 12:37 PM. She followed up at 1:29 PM and stated that Resident #17 was a new admit and should have had a contact precaution sign posted for the foley catheter and in addition the resident had the foley placed related to wounds. Additionally, she stated that Resident #18 was supposed to be on contact precautions as well and the staff would be addressed.Interview on 3/30/26 at 2:30 PM with occupational therapy staff #15 revealed that they rely on the signs posted outside of the resident rooms and stated that if the sign is wrong the PPE is wrong.The overall concerns with signage and staff awareness of resident diagnosis were reviewed with the facility DON and Corporate VP of Clinical Services on 3/30/26.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interviews and record reviews, it was determined that the facility failed to ensure its Infection Preventionist met the mandatory qualifications for the position.The findings include:An Infection Preventionist (IP) is responsible for the facility's Infection Prevention and Control Program. This position requires specialized training in infection control.On 3/24/26 at 10 AM, during an interview with the Director of Nursing (DON), confirmed she/he was the Infection Preventionist for the facility. The DON reported that she/he hasn't completed specialized training in infection control and the facilities staff has no one else who is currently qualified for the position. Further investigation revealed that the previous Infection Preventionist for the facility left in October 2025.On 3/24/26 at 1:30PM the Administrator and DON confirmed that they are currently looking to fill the position of Infection Preventionist for the facility staff. Cross reference F880