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	05/21/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on medical record review and interview, it was determined the facility failed to report two injuries of unknown origin to the Office of Health Care Quality (OHCQ) as required. This was evident for 1 (Resident #3) of 7 residents reviewed during a complaint survey. The findings include:Review of Complaint 3007212 regarding 2 injuries of unknown origin for Resident #3 was conducted on 5/20/26. Review of Resident #3's medical record on 5/20/26 revealed the Resident was admitted to the facility in 2025 with diagnosis to include anoxic brain injury and quadriplegia.During interview with Resident #3's representative (RP) on 5/20/26 at 1:45 PM, the RP stated the Resident had 2 injuries recently that he/she is unaware of how they happened. The RP stated one was a fracture of the right great toe in March 2026 and the second one was a large bruise on the left ankle. The RP stated he/she found out about the fracture of the great toe when the Wound Clinic wanted the toe X-rayed. The RP stated he/she was told about the second injury when he/she called by the facility a few days after going to the Wound Clinic on 4/8/26 and was told the Resident had a new left ankle wound. The RP stated he/she took the Resident to the Wound Clinic on 4/22/26 and that is when he/she saw it was a large bruise and not a wound.1.Review of Resident #3's medical record on 5/20/26 revealed on 3/9/26 the Resident was seen at the Wound Clinic for a new right great toe wound. At that time the Wound Clinic ordered an X-ray of the right great toe.Further review of Resident #3's medical record revealed the X-ray was completed on 3/10/26 with the results received on 3/11/26. The X-ray result was possible nondisplaced age indeterminate fractures through the base of the proximal phalanx of the fifth digit.Interview with the Director of Nursing on 5/21/26 at 11:30 AM confirmed the facility staff did not report the injury of unknown origin to Resident #3's right great toe to OHCQ on 3/11/26.2.Review of Resident #3's medical record on 5/20/26 revealed the Resident had a change in condition documented by Nurse #13 on 4/11/26 at 6:34 AM. Review of Resident #3's change in condition revealed it stated the Resident had a new left ankle pressure area and the Resident's provider and RP were notified.During interview with Nurse #13 on 5/21/26 at 8:35 AM, Nurse #13 stated she was assisting Nurse #15 documenting for Resident #3 on 4/11/26 and couldn't remember what the Resident's left ankle looked like.During interview with Nurse #15 on 5/21/26 at 10:13 AM, Nurse #15 stated she was providing wound care for Resident #3 on 4/11/26 when she removed both the Resident's socks. At that time, she assessed the Resident to have a bruise around the entire left ankle, and it was a little swollen. Nurse #15 stated she reported the injury to day shift.During interview with the Director of Nursing (DON) on 5/21/26 at 11:30 AM, the DON confirmed both Resident #3's injuries were not reported to OHCQ and she was not aware of the left ankle injury until 4/22/26 when the Resident returned from the Wound Clinic.

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a complaint, medical record review and interviews, it was determined the facility staff failed to 1) notify the Resident's case manager of discharge location and 2) ensure home health services were set up for a resident at time of discharge. This was evident for 1 (Resident #5) of 3 residents reviewed for discharge during a complaint survey.The findings include:Review of Complaint 3008101 was conducted on 5/19/26 for a concern Resident #5 was discharged without home health services.Review of Resident #5's medical record on 5/19/26 revealed the Resident was admitted to the facility from the hospital on 4/29/26 with a diagnosis to include cellulitis of right lower limb.1.The facility staff failed to notify the Resident's representative (RP) of discharge location.During interview with Resident #5's community Case Manager/Resident's RP on 5/19/26 at 10:20 AM, the Case Manager stated the Resident was discharged from the facility on 5/6/26 and facility failed to notify her where the Resident was being discharged and failed to set up home health services. The Community Case Manager stated the Resident called her on 5/6/26, told her he/she had been discharged and where he/she was.Further review of Resident #5's medical record revealed the facility staff held a care plan meeting with the Case Manager on 4/30/26 and discussed potential discharge on [DATE] but had not finalized discharge location. On 5/4/26 the Social Services Assistant documented the Case Manager was called and given a discharge date of 5/6/26.During interview with Social Services Assistant (SSA) on 5/19/26 at 10:40 AM, the SSA stated she had called the Resident's Case Manager on 5/4/26 and told her the Resident was being discharged on 5/6/26. SSA stated the Case Manager asked where the Resident was being discharged to. The SSA stated she gave the Case Manager a few options. The SSA stated the Resident was not assigned to her but to the facility's Social Worker so she then notified the Social Worker of the call.During interview with the Social Worker on 5/19/26 at 10:49 AM the Social Worker was asked if he/she notified the Case Manager of the Resident's discharge location and the Social Worker stated no.2. The facility staff failed to set up home health services for Resident #5 at discharge.Review of Resident #5's medical record on 5/19/26 revealed a 5/5/26 Physician #9's Discharge Summary note that stated discharge with home health for continued wound care.Further review of Resident #5's medical record revealed a nurses note on 5/6/26 at 5:27 PM that stated, Resident discharged home without home care.During interview with the facility's Social Worker on 5/19/26 at 10:49 AM, the Social Worker was asked why home health services were not set up for Resident #5 at discharge. The Social Worker stated because the Resident was discharged to a shelter, the Resident was educated on wound care and given wound care supplies at discharge.During interview with Physician #9 on 5/19/26 at 11:40 AM, Physician #9 was asked if he was aware Resident #5 was discharged without home health services. Physician #9 stated no, the Resident should have been set up with home health, and he would assist in making sure the Resident got home health services now.Interview with the Director of Nursing (DON) on 5/19/26 at 2:25 PM confirmed the Resident's Case Manager was not notified of the Resident's discharge location and home health services were not set up at discharge.During interview with the DON on 5/20/26 at 10:55 AM, the DON told the Surveyor home health services have now been set up for Resident #5.

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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 review of a complaint, medical record review and interviews, it was determined the facility staff failed to include the discharge instructions and prescriptions in the resident's medical record. This was evident for 1 (Resident #5) of 3 residents reviewed for discharge during a complaint survey.The findings include:Review of Complaint 3008101 was conducted on 5/19/26 related to the discharge of Resident #5. Review of Resident #5's medical record on 5/19/26 revealed the Resident was discharged from the facility on 5/6/26.Further review of Resident #5's medical record revealed a nurse's note that stated, Resident discharged home without home care, all personal belongings and prescriptions sent with resident.Review of both the Resident's electronic and paper medical records revealed no discharge instructions or prescriptions given to Resident #5 at discharge.Interview with the Director of Nursing on 5/19/26 at 1:53 PM confirmed Resident #5's medical record does not include any discharge instructions or prescriptions that were given to the Resident at discharge on [DATE].

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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. Based on medical record review and interviews, it was determined the facility failed to administer medications as ordered (Resident #2) and failed to administer wound treatments as ordered (Resident #6). This was evident for 2 of 7 residents reviewed during a complaint survey. The findings include:1.The facility staff failed to administer medications as ordered for Resident #2.Review of Complaints 2979772 and 3002392 regarding medication administration was conducted on 5/20/26. Review of Resident #2's medical record on 5/20/26 revealed the Resident was admitted to the facility in April 2025 with a diagnosis to include Ankylosing Spondylitis of the spine. Ankylosing Spondylitis (AS) is and inflammatory form of arthritis that primarily affects the spine, causing chronic pain and stiffness.During interview with Resident #2 on 5/20/26 at 12:45 PM, the Resident stated he/she is not receiving his/her Etanercept injections as ordered.Review of the Resident's physician orders revealed the Resident is ordered to receive Etanercept 50 mg/ml every week. Etanercept is an injection used to treat the signs and symptoms of autoimmune diseases such as Ankylosing Spondylitis.Review of Resident #2's April and May 2026 Medication Administration Records revealed the facility staff failed to administer Resident #2's Etanercept injection on 4/9/26 and 4/23/26.Interview with the Director of Nursing on 5/21/26 at 4:10 PM confirmed Resident #2 did not receive his/her Etanercept injection on 4/9/26 and 4/23/26.2.The facility staff failed to administer wound treatments as ordered to Resident #6.Review of Complaint 3004313 regarding wound care was conducted on 5/19/26 for Resident #6. Review of Resident #6's medical record on 5/19/26 revealed the Resident was admitted to the facility in July 2025 with a diagnosis to include Necrotizing Fasciitis. Necrotizing Fasciitis is a rare but severe bacterial infection that destroys the tissue beneath the skin, including fat and the fascia covering muscles.During interview with Resident #6 on 5/20/26 at 8:13 AM, the Resident stated the facility staff do not always do his/her wound dressings.Review of Resident #6's wound care for March, April and May 2026 revealed the Resident is ordered daily wound treatment to the Resident's right leg and right foot. Review of the Resident's March, April and May 2026 Treatment Administration Records revealed the facility staff failed to administer the treatment ordered to the Resident's right leg and right foot on 3/6, 3/9, 3/16, 3/18, 3/19, 3/26, 3/27, 4/9, 4/10, 4/16, 4/17, 4/23, 4/24, 4/26, 4/29 and 5/6/2026.Interview with the Director of Nursing on 5/20/26 at 9:50 AM confirmed the facility staff did not administer wound treatment as ordered for Resident #6.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review and interviews it was determined the facility failed to provide treatment/services to prevent/heal pressures ulcers as ordered for a resident. This was evident for 1 (Resident #3) of 3 residents reviewed during a complaint survey.The findings include: A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed).Review of Complaint 3007212 regarding pressure ulcer care was conducted on 5/20/26. Review of Resident #3's medical record on 5/20/26 revealed the Resident was admitted to the facility in 2025 with diagnosis to include anoxic brain injury and quadriplegia. During interview with Resident's representative (RP) on 5/20/26 at 1:45 PM, the RP stated he/she takes the Resident to an outside Wound Clinic and is concerned that the Resident's pressure ulcer dressings are not always being done.Review of Resident #3's medical record on 5/20/26 for pressure ulcer care in March, April and May 2026 revealed the Resident went to the Wound Clinic on 3/9/26. Review of the 3/9/36 Wound Clinic discharge instructions revealed the Resident had a sacral Stage IV pressure ulcer and a right great toe Stage III pressure ulcer. The Wound Nurse Practitioner ordered for the sacral pressure ulcer: wound cleanser, normal saline and dressing every day and for the right great toe pressure ulcer: wound cleanser, Iodosorb and dressing every day.Review of Resident #3's March, April and May 2026 Treatment Administration Records revealed the facility staff failed to administer treatment to the Resident's sacral pressure ulcer on 3/10, 3/11, 3/16, 3/26, 3/31, 4/13, 5/11, 5/17, 5/18 and 5/19/2026 and to Resident's right great toe on 3/26, 3/31, 5/1, 5/11, 5/17 and 5/18/2026.Interview with the Director of Nursing on 5/21/26 at 11:30 AM confirmed the facility staff failed to administer treatment to Resident #3's sacral and right great toe pressure ulcers as ordered.