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	06/25/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaint 3027850, observations, and interviews conducted during a complaint survey, it was determined that the facility failed to provide maintenance services necessary to maintain resident rooms and equipment. This issue affected 5 of 12 residents reviewed (#8, #9, #10, #11, #12) and 3 of 3 nursing units observed.The findings include: On 6/24/26 at 9:00 AM a review of complaint 3027850 was conducted regarding environmental concerns. On 6/24/26 at 10:05 AM the following observations were made during environmental walking rounds: Resident Wheelchairs in Disrepair: Damage or missing components (including torn vinyl covering, missing foam padding, and missing armrests) were noted on wheelchairs for Residents #8, #9, #10, #11, and #12. Additionally, two unattended wheelchairs in the 300 hallway had damaged or missing armrests. Ceiling Tiles in Disrepair: [NAME] water stains of various sizes were observed on ceiling tiles in the main lobby, the 300 hallway, and rooms 103, 104, 125, 130, 218, 220, 307, 315, and 317. Missing and loose wood trim around the sink was also noted in room [ROOM NUMBER]. Interviews conducted on June 24, 2026, revealed a breakdown in the maintenance reporting process: - At 10:20 AM: Housekeeper #8 stated she reported repairs verbally to maintenance rather than using the electronic system (TELS).- At 10:46 AM: Maintenance Director #6 stated his expectation was for staff to use TELS for non-emergency repairs. He noted that wheelchair armrests are considered emergencies that require immediate reporting and acknowledged that the stained ceiling tiles were due to roof leaks. The Director of Nursing and the Regional Nurse were informed of these findings on June 25, 2026, at 11:34 AM.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility reported incident 3015069, and interviews, it was determined the facility staff failed to protect a resident from verbal abuse from facility staff. This was evident for 1 (Resident#1) of 4 residents reviewed for abuse during a complaint survey.The findings include: On 6/24/26 at 1:25 PM a review of Resident #1's medical record was conducted and revealed Resident #1 was admitted to the facility on [DATE] from the hospital for rehabilitation following joint replacement surgery and an infection and inflammatory reaction due to internal right knee prosthesis. On 6/24/26 at 1:25 PM a review of facility reported incident #3015069 was conducted and revealed a witnessed event regarding a (GNA) geriatric nursing assistant's verbal conduct toward Resident #1, specifically the use of profanity. The facility's documentation revealed on 5/14/26 at 12:45 PM the facility did an interview with Resident #1 who stated, I just go back in my room so I can get some ice in my bag because my knee has been bothering me and I pressed the buzzer. She (GNA#13) came in and said what do you want, you were just in the wheelchair, you can get it your damn self. Then she came back in and started saying F (expletive language) this and F (expletive) that and then said F (expletive) it I got it. The report documented that licensed practical nurse (LPN) #15 documented that GNA #13 came down to the nurse's station upset and said she quit and put her badge down and walked out. Review of a written statement from the Director of Rehabilitation (DOR) documented the DOR was in the therapy gym. The entry door to the 100 unit was open. All of a sudden there was a loud statement in the hallway. The GNA said the patient wheeling around could get [his/her] own ice. Then she said, F (expletive) it I quit. Review of the facility's investigation revealed GNA #13 was terminated, the facility staff were re-educated on abuse and professional conduct. The Director of Nursing (DON) documented that facility wide resident audits/interviews would be done weekly times 4 weeks and the issue would be reviewed in QAPI. Review of the investigation revealed only 8 residents were interviewed about abuse.Further review of the facility's investigation failed to produce the weekly audits. There were no skin assessments provided to the surveyor for residents who were cognitively impaired. Review of the May 2026 QAPI meeting minutes that were given to the surveyor from the DON failed to produce documentation that verbal abuse or results from resident audits was discussed.On 6/25/26 at 9:05 AM the DON was interviewed and stated that she did not do the weekly audits that they said they were going to do.On 6/25/26 at 10:01 AM the DON was interviewed and stated that she did the initial audit on the facility report and it was an oversight and they were going to start the audits. The DON could not find the education provided to staff but stated she went around and personally educated staff.On 6/25/26 at 10:46 AM Certified Occupational Therapy Assistant (COTA) #12 was interviewed and stated that he was going down to the resident's room to get the resident for therapy. The aide and the resident were arguing about the ice pack. Resident #1 was being a little rude to the GNA, but she did cuss at the resident. She said, F U. COTA #12 said he was just standing there trying to get the resident for therapy and the GNA walked away. The resident said to him, did you hear that and the COTA said, yes. COTA #12 stated he filled out an incident report after it happened. On 6/25/26 at 11:09 AM LPN #15 was interviewed and stated that the resident had the call light on and the GNA went down to answer it and she came back screaming F (expletive) this place, I quit, they were looking for a reason to fire me anyway. LPN #15 stated she checked on the resident to see how the resident was doing and the resident was distraught and upset. The resident stated that GNA #13 was rude to the resident and cussed at him/her. The resident calmed down and came down to the nurse's station to talk to the doctor.On 6/25/26 at 2:15 PM the concerns were discussed with the Regional Nurse, DON, and the Nursing Home Administrator.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on medical record review and interview, it was determined the facility staff failed to assess and monitor residents' nutrition needs and intervene in a timely manner. This was evident for 3 (Resident #3, #6 and #4) of 5 residents reviewed during a complaint survey. The findings include: 1) Review of Complaint 3040167 was conducted on 6/24/26 regarding Resident #3's care at the facility. Review of Resident #3's medical record on 6/24/26 revealed the Resident was admitted to the facility in 2023 with a diagnosis to include dysphagia. Dysphagia is the medical term for difficulty swallowing. Further review of Resident's medical record revealed on 2/16/26 the Resident was seen and assessed by Nurse Practitioner (NP) #17 for weight loss. At that time NP #17 documented: the Resident was 106.6 pounds on 12/3/25 and 100.3 pounds on 2/6/26 with albumin 3.2 and prealbumin < 10 on 1/16/26 on puree/thin diet. Initiate nutrition consult and add oral nutrition supplements. Further review of Resident #3's medical record revealed the Resident was not seen by the Dietitian until 3/8/26, 3 weeks later. At that time the Dietitian documented: supplement liquid protein added twice a day for depressed prealbumin in the presence of skin wounds. There was no documentation regarding the weight loss. Further review of Resident #3's medical record revealed the staff documented the Resident weighed 99 pounds on 3/19/26, 94 pounds on 4/14/26 and 96.2 pounds on 5/9/26. The Resident had a significant weight loss from 3/19/26 until 4/14/26 of 5 pounds or 5.05%. The Resident was not seen again by the Dietitian until 6/3/26. At that time the Dietitian documented: Resident with skin wounds and weight loss trend. Currently on a Pureed diet with liquid protein twice a day, Juven twice a day for 30 days for wound healing. Med Pass twice a day for increased calories and protein. Interview with the Dietitian on 6/24/26 at 1:59 PM, the Dietitian was asked why the Resident was not assessed for prealbumin after NP #17's note on 2/16/26 until 3/8/26, not assessed for weight loss at that time per NP #17's note on 2/16/26, and not after the significant weight loss from 4/14/26 until 6/3/26. The Dietitian stated she only works in the facility 12 hours a week, unable to get all assessments done in a timely manner due to time constraints and was not made aware of NP #17's request for consult for weight loss on 2/16/26 by the facility staff and also stated the Resident's weight did increase in May to 96.2 pounds. Interview with the Director of Nursing (DON) on 6/25/26 at 12:30 PM confirmed the Dietitian did not assess and order liquid protein supplements for Resident #3 timely after the NP #17 2/16/26 note for nutritional consult. The DON also confirmed the Dietitian did not assess the Resident for weight loss until 6/3/26 and add nutritional interventions timely. 2) Review of Complainant 3033039 was conducted on 6/24/26 regarding Resident #6's care at the facility. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's medical record on 6/24/26 revealed the Resident was admitted to the facility in November 2025 with a diagnosis to include dysphagia. Dysphagia is the medical term for difficulty swallowing. Further review of Resident #6's medical record revealed the Resident was not assessed by the Dietitian until 12/10/25, 3 weeks after admission. Further review of the Resident's medical record revealed the facility documented the Resident's weight as 242 pounds on 11/24/25 at time of admission and 247.8 on 12/18/25. The Resident was not weighed in January 2026. Interview with the Dietitian on 6/24/26 at 1:59 PM the Dietitian asked what the expectation for a nutritional assessment on admission is and why the delay in the Resident's admission nutrition assessment. The Dietitian stated ideally a resident would be assessed within 72 hours but due to the Dietitian's limited time in the facility she has to prioritize residents with wounds and significant weight loss first. The Dietitian was asked what are the expectations for residents to be weighed. The Dietitian stated every week for 4 weeks then once a month unless the resident has a significant change. Review of the facility's Weight Monitoring policy implemented on 2/15/24 and provided by the Regional Nurse was conducted on 6/25/26. It stated A weight monitoring schedule will be developed upon admission for all residents: Newly admitted residents-monitor weekly for 4 weeks. All others-monitor weight monthly. Interview with the Director of Nursing (DON) on 6/25/26 at 8:45 AM confirmed the delay in Resident #6's admission nutrition assessment, the Resident was not weighed weekly times four and should have had a monthly weight in January 2026. 3) On 6/24/26 at 11:14 AM a review of complaint 3023641 was conducted along with a review of Resident #4's medical record. Review of the complaint revealed concerns regarding Resident #4's blood sugars, insulins, and the circumstances of the resident's transport to the hospital in Diabetic Ketoacidosis. Diabetic Ketoacidosis (DKA) is a life-threatening condition of diabetes that occurs when the body doesn't produce enough insulin. Proper nutrition management plays a key role in keeping blood sugar stable and preventing DKA. On 6/24/26 at 11:14 AM a review of Resident #4's medical record revealed a 5/14/26 progress note from internal medicine documenting that Resident #4 had highly variable blood glucose levels with multiple readings from 191-540 mg/dl. Normal blood glucose levels before eating in the morning should be between 80 to 130 mg/dl for individuals with diabetes and less than 180 mg/dl after meals. A blood sugar reading over 500 mg/dl can lead to DKA. Review of nutritional assessments for Resident #4 revealed the last comprehensive nutritional assessment was dated 7/10/25. There were no nutritional assessments for the past 11 months. Review of nutrition/dietary notes revealed the last note was 6/18/26 that documented, currently on a renal, thick liquid diet. RD (registered dietician) from dialysis is requesting double protein with meals. Order updated. The previous dietary note was dated 9/25/25 regarding a weight warning. There were (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no dietary notes between 9/25/25 and 6/18/26 in which another dietician recommended the upgrade. On 6/24/26 at 12:39 PM an interview was conducted with Nurse Practitioner (NP)#5, who confirmed that Resident #4 was a brittle diabetic. On 6/25/26 at 9:52 AM an interview was conducted with the Medical Director (MD) #3, who confirmed that Resident #4's blood glucose levels were all over the place. MD #3 was asked if nutritional assessments should be done regularly since the resident has had issues with blood glucose control and DKA. MD #3 stated it was unacceptable that there were no recent nutritional assessments from the dietician and that he expected the resident would be followed closely due to his/her diabetes and renal status. On 6/25/26 at 11:18 AM an interview was conducted with Dietician #9. Dietician #9 stated that she had talked to Resident #4 several times and that the resident was very noncompliant, snacked, and had progressive kidney failure. Dietician #9 stated, I have seen [him/her] and have talked to [him/her] several times. When asked where her documentation was she said, I try to document. When I am here on Thursdays I get pulled. It is challenging. This is a high acuity building in terms of resident care. When I come in I try to prioritize. I look up wounds and weight losses. I do new assessments on admission and then quarterly. Usually for a quarterly assessment I may just do a note. If there is no quarterly note then it probably was not done. If [he/she] is not losing weight and doesn't have wounds, then I wouldn't see because the wound patients and weight loss patients would take precedence. I work 12 hours a week and that is not enough. They have not offered me more hours. I am still doing MDS assessments care plans, care plan meetings, QAPI, weight audits, and checks. I am doing the best I can with the time that I am here. [He/She] would be much more of a priority about educating about the kidney disease. Dietician #9 did confirm that there was not an assessment since July 2025 and there were no dietary assessments or notes since September 2025. On 6/25/26 at 11:34 AM the Director of Nursing and Regional Nurse were informed of the findings and expressed that they understood the surveyor's concerns.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of a complaint, record review, and interview, it was determined the facility failed to provide timely medication to meet the needs of a resident. This was evident for 1 (Resident #6) of 5 residents reviewed for complaints during a complaint survey.The findings include: On 6/24/26 a review of complaint 3033039 was conducted for Resident #6's care at the facility. Review of Resident #6's medical record on 6/24/26 revealed the Resident was admitted to the facility in November 2025 following a hospitalization. Further review of the Resident's medical record revealed on 2/6/26 Nurse Practitioner (NP) #5 ordered the Resident to have Ertapenem 1 Gram intravenously 1 time a day for UTI (Urinary Tract Infection) for 10 days. Review of Resident #6's February 2026 Medication Administration Record revealed the Resident did not receive Ertapenem until 2/10/26, 4 days later. Further review of Resident #6's medical record revealed the following nurses' notes: On 2/7/26 at 9:47 PM a nurse's note stated: Ertapenem 1 gram intravenously one time a day for UTI for 10 days. Awaiting pharmacy delivery. Provider aware. On 2/8/26 at 9:17 PM a nurse's note stated: Ertapenem 1 gram intravenously one time a day for UTI for 10 days. Awaiting pharmacy delivery. On 2/9/26 at 4:13 PM a nurse's note stated: Ertapenem 1 gram intravenously one time a day for UTI for 10 days. Waiting from pharmacy. Interview with the Regional Nurse on 6/25/26 at 11:29 AM confirmed the Resident did not receive Ertapenem 1 gram as ordered by provider on 2/6, 2/7, 2/8 and 2/9/26.