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	09/05/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and resident interview, the facility failed to ensure that a resident's dignity was maintained for 1 of 3 residents reviewed for privacy during observation rounds and failed to ensure that staff wore facility-issued identification badges while providing resident care. This was evident for 5 staff observed during the survey. The findings include: 1. On 9/2/25 at 10:00 AM, during observation rounds, Resident #74 was observed lying in bed near the door with his/her Foley catheter bag exposed and visible to anyone walking by in the hallway. The bag was not covered with a privacy bag. During an interview with Resident #74 on 9/2/25 at 10:10 AM, the resident stated, My bag is always like this.The facility's failure to maintain resident dignity had the potential to cause embarrassment, loss of self-respect, and decreased quality of life. 2. On 9/2/25 at 8am during a facility-wide observation, multiple staff members, including Geriatric Nursing Assistant (GNA #15), Licensed Practical Nurse (LPN #11), and Registered Nurses (#3, #27), were observed providing direct care and services without visible facility-issued identification badges.During an interview on 9/2/25 at 9am, Resident #12 stated, Sometimes I don't know who is coming in my room because they don't have a badge on. I don't know if they are really staff.On 9/2/25 at 9:30am, Staff # 3 acknowledged not wearing a badge, stating, I just started working here recently and the ID badge machine is not working.The Director of Nursing confirmed during an interview on 9/2/25 at 10am that all staff are required to always wear ID badges while on duty and acknowledged staff were not following policy.The Human Resources Assistant (Staff #6) confirmed during an interview on 9/2/25 at 1pm, that the ID badge machine was not working. She stated that a replacement was on order.Review of the facility policy titled Employee Identification Badges states: All employees must always wear a name badge so that residents can identify them. The Company provides name badges. All name badges are to be supplied by The Company.The facility's failure to ensure staff wore identification badges compromised resident dignity, rights, and safety by preventing residents from knowing the identity of individuals providing care.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews with facility staff it was determined the facility failed to ensure that resident's rooms were properly maintained and their environment was homelike. This was found to be evident for 2 resident rooms observed on the 100 hallway during the facility's survey.Findings include,While conducting an initial tour on 9/2/25 at 9:20AM of the 100 hallway, an observation was made of Resident # 2's bathroom. On the right side of the wall above the baseboards there was a large spackled area that was in need of paint. Further observations were made of Resident # 33's room on the same date at approximately 9:50AM and the wall area behind the bed was completely marred and in need of repairs. The Administration team was made aware of the concerns at the exit conference on 9/5/25 at 1:45 PM.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review and staff interview, the facility failed to ensure that residents were free from misappropriation of property when Registered Nurse (RN) #25 misappropriated Resident #76's prescribed oxycodone following discharge from the facility. This deficient practice was evident for 1 Resident (#76) reviewed for medications. Findings include:Oxycodone is a controlled opioid medication with a high potential for misuse, addiction, and dependence. Proper handling and destruction of controlled medications is required to ensure resident safety and prevent diversion. On 09/05/2025 at 11:27 AM, during investigation of Facility Reported Incident (FRI) 358648, it was discovered that in August 2024, RN #25 removed Resident #76's oxycodone from the medication cart following the resident's discharge from the facility. Documentation review revealed RN #25 documented the medication as wasted. Licensed Practical Nurse (LPN) #24 cosigned the narcotic destruction record, indicating the medication had been destroyed, despite not physically witnessing the destruction. During interview, the Director of Nursing (DON) reported that after discharge, Resident #76 contacted the facility inquiring about the status of his/her prescribed oxycodone. At that time, an internal investigation was initiated. As part of the investigation, RN #25 was drug tested and returned a positive result for oxycodone. RN #25 was subsequently terminated from employment and reported to the Maryland Board of Nursing.The facility failed to ensure appropriate accountability and destruction of controlled substances and failed to protect Resident #76 from misappropriation of property when nursing staff diverted the resident's prescribed medication.

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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 record review and staff interview, the facility failed to ensure that allegations of misappropriation of resident (#76) property were reported to the Office of Health Care Quality (OHCQ) as required. This was evident for 1 resident. Findings include:On 09/05/2025 at 11:27 AM, while investigating Facility Reported Incident (FRI) 358648, it was discovered that Registered Nurse (RN) #25 misappropriated Resident #76's oxycodone from the medication cart in August 2024 following the resident's discharge from the facility. Documentation showed RN #25 recorded the medication as wasted. Licensed Practical Nurse (LPN) #24 cosigned the narcotic sheet with staff #25, although LPN #24 reported she did not physically observe the destruction of medication.During an interview with the Director of Nursing (DON), she stated that after Resident #76 was discharged , the resident contacted the facility to inquire about the missing medication. At that time, an internal investigation was initiated, and RN #25 tested positive for oxycodone use. RN #25 was subsequently terminated and reported to the Maryland Board of Nursing. However, the facility did not report the misappropriation/diversion of controlled medications to the Office of Health Care Quality (OHCQ) as required.During an interview with the Corporate Nurse, she stated the incident was not reported to OHCQ because it was discovered after the resident had discharged from the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and interviews with facility staff it was determined the facility failed to follow the resident careplan to ensure ongoing communication between the dialysis center and the facility for continuity of care for a resident receiving dialysis services. This was found to be evident for 1 (Resident # 93) of 3 residents reviewed for dialysis during the facility's survey.Findings include,An interview was conducted with the DON (# 2) on 9/3/25 at 11:35 AM and she was asked to explain how the facility communicates with the dialysis center regarding Resident # 93. The DON stated that there is a communication book that is carried with the resident when s/he goes to dialysis. The DON further stated that the resident is a health care professional and likes to keep the dialysis book on person. The survey team asked the DON how clinical information regarding the resident status is communicated from the dialysis center to the facility if the book remains with the resident. The DON stated that the staff at the dialysis center sometimes call the facility with updates. The DON stated the resident is care planned to keep the dialysis book on person and will provide documentation to the survey team.During a subsequent interview with the DON at 1:20PM, she confirmed that the resident does not have a care plan to keep the dialysis book. She obtained copies of the resident dialysis communication records and provided them to the survey team. Upon review, it was noted that multiple forms dated 7/11, 7/21, 7/23, 7/25, 8/1, 8/6, 8/11, 8/15, 8/18, 8/25, 8/27, 9/1, and 9/3/2025 did not have any information documented from the dialysis center. There was no documentation of the resident vital signs or weights. The DON stated that there was a disconnect regarding communication between the dialysis facility and the NH and that the facility was working on this.All concerns were discussed with the Administration team on 9/5/25 at 1:45 PM at the exit conference.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and staff interview, the facility failed to ensure that services provided met professional standards of quality by not maintaining accountability and proper destruction of controlled substances, resulting in the misappropriation of Resident #76's prescribed oxycodone. This deficient practice involved 1 resident (#76) reviewed.Findings include:Oxycodone is a controlled opioid medication with a high potential for misuse, addiction, and dependence. Proper handling and destruction of controlled medications is required to ensure resident safety and prevent diversion.On 09/05/2025 at 11:27 AM, during investigation of Facility Reported Incident (FRI) 358648, it was discovered that in August 2024, RN #25 removed Resident #76's oxycodone from the medication cart following the resident's discharge from the facility.Documentation review revealed RN #25 recorded the medication as wasted. Licensed Practical Nurse (LPN) #24 cosigned the narcotic destruction record, indicating the medication had been destroyed, despite not physically witnessing the destruction.During interview, the Director of Nursing (DON) reported that after discharge, Resident #76 contacted the facility inquiring about the status of his/her prescribed oxycodone. At that time, the facility initiated an internal investigation. As part of the investigation, RN #25 underwent drug testing, which returned positive for oxycodone. RN #25 was subsequently terminated from employment and reported to the Maryland Board of Nursing.

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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 observations, record review, and staff and resident interviews, it was determined that the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice. This was evident for 1 (Resident #59) out of 40 residents reviewed during the survey.The findings include: On 9/02/2025 at 8:52 AM, the surveyor began their initial observation of Resident #59 who was sleeping at this time. Later that day, around 1 PM, the surveyor returned and discussed in detail with Resident #59, their wound care and having maggots in their wound 2 times. The first time occurred about a week after he/she arrived at the facility. Resident #59 stated that it wasn't that many, I didn't even know they were there until the nurse was doing the dressing change. But the second time was last week, and there were more; I could feel them moving around. Resident #59 was asked if this was reported. Their reply was, Yes, there was a nurse and the unit manager. On 9/04/2025 at 10:20 AM, the surveyor spoke with the Unit Manager #3 for Unit 3, who was also the ADON, and asked her if she was aware that Resident #59 had maggots in their wound. She stated that she was informed. Then she was asked if she had any documentation in reference to this happening. The Unit Manager #3 stated that she would look into it and get back with the surveyor. On 9/04/2025 at 10:35 AM, the surveyor spoke with the DON #2 and asked if she was aware of a resident having maggots in their wound and if she had any documentation for it. DON #2 stated that she would have to follow up with the surveyor regarding this matter. During record review on 9/4/25, the surveyor was unable to locate any documentation in progress notes that the incidents with wound care occurred, looking all the way back to when Resident #59 first arrived, to the present. Resident #59 had orders written on 7/30/25, which state to Cleanse with VASHE. Apply Xeroform to the base of the wound. Secure with ABD, Kerlix, and Ace bandage. Change daily and PRN. Please date and time dressing every day and night shift. When reviewing the Treatment Administration Record for August and September 2025, it revealed that the nurses were signing off every day and night shift that the dressing was being changed. On 9/4/25 at 1:03 PM, the facility failed to provide any documentation of when Resident #59 stated and showed that he/she had maggots in their wound on the 2 occasions. The Unit Manager #3 stated that she was aware of the situation; however, she was unable to find any documentation of when the incidents occurred. On 9/04/2025 1:25 PM, the surveyor followed up with the DON #2 and the ADON #3 about their knowledge of Resident #59 having maggots in their wound and not having any documentation of the incidents. Both the DON #2 and the ADON #3 stated that there was no documentation, and they were unable to provide a reason or solution. On 9/04/2025 at 3:18 PM, during a wound dressing change for Resident #59, it was noted that the present dressing was dated and timed, 9/1/25 at 7:30 PM, and had been initialed (which was unreadable). The surveyor made the nurse doing the dressing change aware that it was the last change on 9/1/25. The nurse did not reply. There was a GNA (GNA #33) present to assist with the dressing change also witnessed the date and time of the dressing. On 9/5/2025 at 9:30 AM, the surveyor spoke with the ADON #3 and with the nurse (RN #21) who did the dressing change on 9/4/25, to inform her that the dressing was dated 9/1/25 at 7:30 PM as the last time the dressing had been changed, before RN #21 did the dressing change on 9/4/25. The ADON #3 stated that she understood.

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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 observations, record review, and resident and staff interviews, it was determined that the facility failed to ensure that a resident received their assistive devices to maintain vision. This was evident for 1 (Resident #7) out of 1 resident reviewed for hearing and vision services during the survey.The findings include: On 9/02/2025 at 3:31 PM, the surveyor was able to speak with Resident #7 about his/her concerns during their stay at the facility. Resident #7 stated that s/he has been paying for vision insurance and needs their glasses. Resident #7 stated that he/she saw the eye doctor a while back this year, but still has not received their glasses. On 9/04/2025 at 12:35 PM, a record review revealed that Resident #7 had a prescription for glasses dated February 10, 2025; however, the resident stated that s/he had not received any new glasses this year. On 9/04/2025 at 12:45 PM, the ADON #3 was asked how a resident would get their glasses when they have a prescription. She stated that she was not sure and would get back with that information. On 9/05/2025 at 10:45 AM, the business manager, Staff #35, was asked about Resident #7 and their additional insurance through the facility. Staff #35 informed the surveyor that Resident #7 does have additional dental insurance, but not vision. She continued to state that she was not sure how the vision part works, but it is free for Resident #7. On 9/05/2025 at 12:16 PM, the DON #2 was asked how a resident would get their glasses when they already have a prescription from earlier in the year. The DON #2 stated that the eye doctor orders the glasses for them at the time of their appointment and mails them to the facility. She continued to state that she had received 3 pairs of glasses without the correct invoices with them, and she was unsure who they were for. The DON #2 then announced that she was going to take them to the resident and see if any of them were theirs. Minutes later, the DON #2 returned and stated that Resident #7 tried on a pair of the glasses and found that the pair they tried on actually belonged to them. The DON #2 was asked for copies of the invoices that she had received for the glasses. After reviewing the invoices, it was noted that the dates on these invoices were for May 21, 2025, and not for February. And there were still 2 pairs of glasses that the DON #2 had that were not accounted for.

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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 medical record review and interviews with the resident and facility staff it was determined the facility failed to ensure that a wheelchair used for transporting residents had leg lifts in place prior to transport. This was found to be evident for 1 (Resident # 19) of 40 residents reviewed during the survey.Findings include:Record review revealed Resident #19 was admitted with the following but not limited diagnosis: Pyogenic Arthritis (serious and painful infection of a joint) and Pain in Right Knee. An interview was conducted with resident # 19 on 9/2/25 at 10:30AM. The resident was lying in bed with a pillow placed underneath the uncovered knee area that appeared to be swollen. The resident told the surveyor that his/her right leg was healing, but recently, his/her leg was bent backwards while in therapy. The resident went on to say that on the same day that his/her leg was bent back while in therapy, their knee was bent backwards while being pushed in the wheelchair by therapy staff (# 18). The resident stated that the area was not injured or fractured, but remained a little swollen. An interview was conducted on 9/4/25 at 10:50AM with the Director of Rehabilitation (DOR), staff # 17 and she was asked about the resident leg being bent while receiving therapy. The DOR explained that on the previous Friday which was 8/29/25, during therapy, a Physical Therapy Assistant (PTA) staff # 18 was working with the resident on their posture, and while holding onto the grab bars, the resident legs weakened causing them to bend further backwards. The DOR went on to say that on the same date, Friday 8/29/25 while staff # 18 was pushing the resident in the wheelchair with their legs lifted in the air, the resident legs became tired and bent backwards because the wheelchair did not have legs lifts attached. The DOR stated that leg lifts should have been placed on the wheelchair for the resident during transport. The Administration team was made aware of all concerns at the time of exit on 9/5/25 at 1:45 PM.

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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 record review and staff interview, the facility failed to ensure resident records were complete and accurate when the Assistant Director of Nursing (ADON) falsified resident (#12's) weights; failed to include the indication for use of an anticoagulant medication (Xarelto) on the Medication Administration Record (MAR) and Physician Order Sheet (POS) for one resident (#80) and failed to document a change in condition for a resident (#59). This occurred for 3 of 40 residents reviewed during the survey. Findings include: 1. Review of resident #12's medical record revealed the following documented weights: 09/05/24 – 120.6 lbs. (pounds) 10/15/24 – 129.1 lbs. (8.5 weight gain) 11/11/24 – 130.6 lbs. (11 weight gain) 12/10/24 – 142.4 lbs. (21.6 weight gain) 12/17/24 – 141.6 lbs. (21 weight gain) 12/23/24 – 141.4 lbs. (21 weight gain) 12/31/24 – 140.9 lbs. (20 weight gain) 01/02/25 – 140.9 lbs. (20 weight gain) 01/03/25 – 140.9 lbs. (20 weight gain) 02/02/25 – 122.8 lbs. (18.1 weight loss) These entries indicated repeated, significant, and inconsistent fluctuations in weight. During an interview with the Dietician on 9/4/25 at 10:00 AM, she stated that the weights were inaccurate and that several residents had weights documented inaccurately. During an interview with the Director of Nursing (DON) on 9/4/25 at 11am, she stated that an internal investigation had been initiated in December of 2024, regarding inaccurate weights. She further revealed that the previous Assistant Director of Nursing (ADON) was terminated after the investigation determined that she was falsifying resident weights. The DON stated that Resident #12 was not being weighed; however, weights continued to be documented in the clinical record. She stated the investigation revealed the resident did not have a true weight loss. This failure resulted in incomplete and inaccurate clinical records and had the potential to compromise the health and safety of residents by interfering with appropriate care planning and nutritional management. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 09/05/2025 at 11:34 AM, Resident #80's MAR and POS record review revealed an order for Xarelto 20 mg, one tablet by mouth every evening. Neither document contained a diagnosis or indication for the use of the medication. Record review identified Resident #80's diagnoses to include depression, anxiety disorder, type 2 diabetes mellitus, and chronic atrial fibrillation. During an interview on 09/05/2025 at 12:00 PM, the Assistant Director of Nursing stated that a diagnosis should be documented on the MAR and POS to clarify the reason the resident is receiving the medication. After surveyor intervention, the facility updated the MAR and POS to include the indication for Xarelto. 3. On 9/02/2025 at 8:52 AM, the surveyor observed Resident #59 who was sleeping at this. Later that day, around 1 PM, the surveyor returned and discussed in detail with Resident #59, having maggots in their wound 2 times. The resident advised the first time occurred about a week after he/she arrived. Resident #59 stated that it wasn't that many, I didn't even know they were there until the nurse was doing the dressing change. But the second time was last week, and there were more; I could feel them moving around. Resident #59 was asked if this was reported. Their reply was, Yes, there was a nurse and the unit manager. On 9/04/2025 at 10:20 AM, the surveyor spoke with the Unit Manager #3 for Unit 3, who is also the ADON, and asked her if she was aware that Resident #59 had maggots in their wound. She stated that she was informed. Then she was asked if she had any documentation in reference to this happening. The Unit Manager #3 stated that she would look into it and get back with the surveyor. On 9/04/2025 at 10:35 AM, the surveyor spoke with the DON #2 and asked if she was aware of a resident having maggots in their wound and if she had any documentation for it. DON #2 stated that she would have to follow up with the surveyor regarding this matter. During record review on 9/4/25, the surveyor was unable to locate any documentation in progress notes that the incidents occurred, looking all the way back to when Resident #59 first arrived, to the present. Resident #59 had orders written on 7/30/25, which state to Cleanse with VASHE. Apply Xeroform to the base of the wound. Secure with ABD, Kerlix, and Ace bandage. Change daily and PRN. Please date and time dressing every day and night shift. When reviewing the Treatment Administration Record for August and September 2025, it revealed that the nurses were signing off every day and night shift that the dressing was being changed. On 9/4/25 at 1:03 PM, the facility failed to provide any documentation to the surveyor of when Resident #59 stated and showed that he/she had maggots in the wound on the 2 occasions. The Unit Manager #3 stated that she was aware of the situation; however, she was unable to find any documentation of when the incidents occurred. On 9/04/2025 1:25 PM, the surveyor followed up with the DON #2 and the ADON #3. Both the DON #2 and the ADON #3 stated that there is no documentation, and they were unable to provide a reason or solution.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with facility staff, it was determined that the facility failed to ensure that infection control guidelines were being followed. This was found to be evident for 1 of 3 units toured and during medication administration observations for the survey.The findings include:1. An initial tour was conducted of the 100-unit on 9/2/25 at 9:30AM and the hand sanitizer dispenser was empty for four dispensers. Two of the empty dispensers were sitting on top of the Personal Protective Equipment (PPE) Cart and the other 2 empty dispensers were located on the wall next to the nurse station, across from room [ROOM NUMBER] and on the wall across from the nurse station, near room [ROOM NUMBER]. The nurse (Staff # 11) was made aware and informed the environmental staff worker that was on the unit of the concern. The dispensers were filled by staff. The Administration team was made aware of all concerns at the exit conference on 9/5/25 at 1:45 PM. 2. On 9/3/25 at 11:30 AM, during observation rounds, RN staff #22 was observed standing at the medication cart. Resident #87 was seated in the hallway beside the medication cart. RN staff #22 was observed plucking medications directly from a resident's blister pack into his bare hands, then placing the medications into a medication cup. On top of the medication cart, another pill cup containing eight (8) medications was observed pre-poured and unattended. When questioned by the surveyor about the pill cup, RN staff #22 stated: I am going to administer the medications to the resident after I give resident #87 his/her medications. On 9/04/2025 at 8:45 AM, the surveyor observed LPN # 20 popping medication from the blister package into her hand and then dropping them into the pill cup for a resident. The surveyor interrupted LPN # 20 and asked if it was okay to observe her during her medication administration of morning medications. LPN # 20 said, Sure. The nurse continued to finish up with the current resident and stated that she would be right back after this administration to begin with the surveyor. When LPN #20 returned, she sanitized her hands with hand sanitizer on the medication cart and went to the computer to look up the next resident. The medications were reviewed and LPN #20 ensured that all medications were present. LPN #20 began to pop the medication from the blister package into her hand again and then stopped and popped the medication directly into the pill cup. After completion of medication administration observation, the LPN #20 was informed that she had been seen previously popping the medication from the blister package directly into her hand, and this was not following the infection control guidelines. LPN #20 acknowledged that she was incorrect and that is why she stopped herself from continuing to do so during the rest of the medication administration.