STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215207	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lochearn Nursing Home, LLC	4800 Seton Drive Baltimore, MD 21215

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on complaint, record review, and interview, it was determined that the facility staff failed to inform a resident's representative of a fall with injury and subsequent transfer to the hospital. This was evident for 1 (#7) of 12 residents reviewed for complaints during a complaint survey.The findings include: On 10/2/25 at 9:16 AM a review of complaints 326854 and 2561080 alleged that Resident #7 was transferred and sustained a fall with injury and that family were not notified On 10/2/25 at 9:16 AM Resident #7's medical record was reviewed and revealed a 6/6/25 at 13:01 (1:01 PM) nurse's note that documented, during care while attempting to place Hoyer pad under pt., pt. turned too far over rolling out of bed. The note continued, MD made aware of pt. fall. Review of a 6/6/25 at 13:09 (1:09 PM) change in condition note documented that the physician was aware of the fall and ordered an x-ray to the knee and pain medication. Review of a 6/6/25 at 22:05 (10:09 PM) change in condition note documented that the results of the x-ray were received and Resident #7 had a right knee distal fracture. The physician was made aware and ordered for the resident to be sent to the emergency room for evaluation. There was no documentation in the resident's medical record that the resident's family was made aware of the fall with injury and transfer to the hospital. On 10/8/25 at 11:20 AM the Assistant Director of Nursing (ADON) was interviewed and stated that if the resident has a BIMS (Brief Interview of Mental Status) of 15 and is their own RP (responsible party) then we don't notify the family unless the resident tells us to. On 10/8/25 at 1:20 PM an interview was conducted with Resident #7. Resident #7 was asked if the facility had permission to notify his/her daughter about any issues related to the resident and Resident #7 said, yes. On 10/8/25 at 1:45 PM the Director of Nursing (DON) was interviewed and stated, a patient that is cognitively intact is usually the responsible party for themselves. Anything going on with them we communicate with them. We do not communicate with family members. It depends on who is working with them if they can communicate with family. If the patient is going to the hospital for a fall, we will give them the bed hold policy, and they can communicate with families as they are responsible for self. It is only valid for patients responsible for self. The surveyor asked, even if a resident has a pain level of 8 with a fracture to the leg, you would not notify the family. The DON stated, not if the resident has a BIMS of 15 and is their own RP.

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 ensure home health services were set up for a resident at discharge (Resident #19). This was evident for 1 of 3 residents reviewed for discharge during a complaint survey. The findings include:Review of Complaint 326835 was conducted on 10/2/25 for a concern Resident #19 was discharged without home health services. Review of Resident #19's medical record on 10/2/25 revealed the Resident was admitted to the facility in April 2024 following a hospitalization with a diagnosis to include POTS (Postural Orthostatic Tachycardia Syndrome). Review of the hospital Discharge summary dated [DATE] revealed the Resident received daily IV fluid bolus at home prior to admission.Further review of Resident #19's medical record revealed the Resident was receiving IV fluid daily in the facility.On 7/26/24 at 12:08 PM Staff #23, former Social Services, documented progress meeting held. Staff #23 also documented Resident plans to return home independently. Resident prefers to work with Home Health Agency [A,] but they do not take his/her insurance and was referred to Home Health Agency [B] who will provide PT (Physical Therapy), OT (Occupational Therapy), SLP (Speech Language Pathology), SW (Social Work), SN (Skilled Nursing) and aide.Review of Resident #19's closed paper medical record revealed a Post-Discharge Plan of Care document signed by the Resident on 8/6/24. On the document under Home Health Agency or Visiting Nurse was written PT, OT, SLP, SN, SW, aide and a phone number listed. The Surveyor called the phone number listed on 10/3/25 at 12:54 PM and it was answered with an automated message that identified the number was for Home Health Agency B. The Surveyor then spoke to Home Health Agency B Staff #27 who stated Resident #19 was referred to their agency by the facility. Home Health Agency B Staff #27 also stated the Agency did not take the Resident's insurance so they did not accept the Resident for home health services and notified the facility on 8/6/24.Interview with the Administrator on 10/3/25 at 1:30 PM confirmed the facility failed to ensure Resident #19 had home health services at discharge.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, medical record review, and interviews, it was determined that facility staff failed to thoroughly evaluate and revise a resident's plan of care after each MDS (Minimum Data Set) assessment to reflect accurate and current interventions (Resident #17). This was evident for 1 of 19 residents reviewed during a complaint survey. The findings include: Minimum Data Set- The 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 A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Review of Resident #17's medical record on 10/2/25 revealed the Resident was admitted to the facility in August 2024 with diagnosis to include spinal cord injury and quadriplegia. Further review of Resident #17's medical record revealed the staff conducted an MDS Quarterly Assessment on 9/18/25 and coded the Resident with a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating no cognitive impairment. Further review of Resident #17's 9/18/25 Quarterly MDS Assessment revealed in Section GG0130 Self-Care the facility staff coded the Resident as dependent for eating, oral hygiene, toileting, shower/bathe, dressing and personal hygiene. Dependent coding indicates the Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident #17's care plans on 10/6/25 revealed a care plan titled: Self-care deficit related to musculoskeletal impairment as evidenced by weakness and spinal cord injury with approaches for bathing/showering, bed mobility, dressing and eating as independent. Observation of Resident #17 on 10/6/25 at 11:46 AM revealed the Resident in bed with heel protectors in place and bilateral fall mats next to the bed. During interview with the Resident at that time, the Resident was asked if he/she turns him/herself or do the staff turn the Resident. The Resident stated the staff turn him/her. The Resident also stated the staff bathe him/her and cut his/her nails. During interview with the Director of Nursing (DON) on 10/7/25 at 9:55 AM, the Surveyor reviewed Resident #17's Self-care deficit care plan and asked the DON if the Resident is independent or dependent. The DON stated the Resident is dependent and would follow up with the Surveyor regarding the care plan. Interview with the Director of Nursing on 10/7/25 at 2:00 PM confirmed the Resident is dependent on staff for bathing/showering, bed mobility, dressing and eating. The DON also stated the Self-care deficit care plan is not accurate and will be corrected to indicate the Resident as dependent.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on complaint, medical record review, and interviews, it was determined the facility staff failed to thoroughly assess a resident for pain after a fall with fracture. This was evident for 1 (#7) of 12 residents reviewed for complaints during a complaint survey.The findings include: Pain is often regarded as the fifth vital sign regarding healthcare because it is accepted now in healthcare that pain, like other vital signs, is an objective sensation rather than subjective. As a result, nurses are trained and expected to assess pain. A component of pain assessment-focusing on words to describe pain, intensity, location, duration, and aggravating or alleviating factors. On 10/2/25 at 9:16 AM a review of complaints 326854 and 2561080 alleged that Resident #7 was rolled out of bed during care and sustained a fall with injury. The complaint alleged that during a phone call Resident #7 was screaming in pain periodically during the call. The complaint alleged that Resident #7, laid with a broken leg for more than 6 hours before being transferred to the hospital. On 10/2/25 at 9:16 AM Resident #7's medical record was reviewed and revealed a 6/6/25 at 13:01 (1:01 PM) nurse's note that documented, during care while attempting to place Hoyer pad under pt., pt. turned too far over rolling out of bed. The note continued that the physician was made aware of the resident's fall, and a new order was obtained for x-ray and Tylenol for pain which was administered pending x-ray to the knee. Review of a 6/6/25 at 14:38 (2:38 PM) plan of care note documented, complained of pain to right knee, slight swelling noted, and resident was medicated for pain. The note ended, continue to monitor for effective pain management and make adjustments as needed. Review of a 6/6/25 at 22:05 (10:09 PM) change in condition note documented that the results of the x-ray were received and Resident #7 had a right knee distal fracture. The physician was made aware and ordered for the resident to be sent to the emergency room for evaluation. The note documented that the patient continued on extra strength Tylenol for pain which was administered with some relief. This note was written by the Assistant Director of Nursing (ADON) on 6/9/25, which was 3 days later. Review of Resident #7's medical record revealed under the vital sign section documentation of pain levels. On 6/6/25 at 12:54 PM the pain level was 8 out of 10. On 6/6/25 at 13:08 (1:08 PM) the pain level was 8 and on 6/6/25 at 20:55 (8:55 PM) the pain level was 8.Further review of Resident #7's medical record revealed there were no pain assessments between 1:08 PM and 8:45 PM when the resident arrived at the emergency room and received 2 mg. of IV morphine per emergency room records.Review of Resident #7's Medication Administration Record (MAR) was void of any pain medication being administered, including the Tylenol that a nursing note documented as given. There were no follow up assessments after the Tylenol was documented as given as to if it was effective. There were no additional pain assessments conducted. On 10/8/25 at 11:20 AM the ADON was interviewed and confirmed that the MAR did not have any documentation of Tylenol being administered. The ADON was asked if she was in the building the evening of the fall and saw the resident take the Tylenol and the ADON stated, no. The ADON was asked why her name was on the nursing note dated 6/6/25 at 22:09 that documented Tylenol was given. The ADON said she locked the note. The ADON was asked if she could confirm by looking at the medical record that pain assessments were done and that the resident was medicated for pain from the time of the fall until transport to the hospital. The ADON stated that she could not. On 10/8/25 at 1:20 PM an interview was conducted with Resident #7. Resident #7 was asked if he/she received pain medication after the fall. Resident stated he/she thought he/she got Tylenol but did not know how much. Resident #7 stated that it did not help the pain and that he/she was in pain until after he/she went to the hospital.On 10/8/25 at 2:30 PM the Director of Nursing and Nursing Home Administrator were informed of the concerns.

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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 and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards (Resident #16). This was evident for 1 of 19 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. Review of Resident #16's medical record was conducted on 10/2/25 for Complaint 326847 in December 2024 related to the facility managing the Resident's diabetes. Review of the Resident's medical record revealed the Resident was admitted to the facility in January 2024 with a diagnosis to include Diabetes. Review of Resident #16's December 2024 Medication Administration Record revealed on 12/2/24 the facility staff documented the Resident's 12:00 PM blood sugar (BS) was 401 but failed to document the insulin given. On 12/12/24 at 11:00 AM the facility staff documented the Resident's blood sugar was 17 with no nurse's note. On 12/13/24 at 11:00 AM the facility staff failed to document the Resident's blood sugar. Interview with the Director of Nursing on 10/7/25 at 2:05 PM confirmed the facility staff failed to document the insulin given on 12/2/24 at 12:00 PM, failed to document an accurate blood sugar on 12/12/24 at 11:00 AM and failed to document the blood sugar on 12/13/24 at 11:00 AM for Resident #16.