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	01/08/2026

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 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 observations and interviews, it was determined that the facility failed to treat residents with dignity and respect as evidenced by staff standing over residents while assisting them to eat. This was evident for 1 (resident #52) out of 1 resident observed for dignity during the annual survey.Findings include:On 01/05/2026 at 9:29 AM Resident #52 was observed sitting in a wheelchair in the Activities room at the table with their breakfast tray in front of them. Geriatric Nursing Assistant (GNA) #16 was standing to the left of the resident with a fork in hand and feeding the resident. Additionally, observed seated at the table were 3 other residents in their wheelchairs, Activities Assistant Staff #25, and a vacant chair at the opposite end of the table. This Surveyor asked GNA #16 if the facility has a Feeder program and training; GNA staff #16 stated No. Then asked, was this resident designated to be assisted or fed; GNA staff #16 stated we encourage him/her to eat and we help sometimes. When asked if a chair is available to use while feeding the resident when needed, GNA staff #16 stated, yes, I should be seated, but this resident is not a Feeder, I'm just assisting them at times. On 1/5/2026 at 10:51 AM during an interview with DON #2, Regional Nurse staff #3 and NHA staff #1, this Surveyor shared the findings of, Resident #52 being fed by GNA #16 while standing, despite there being an available chair in the room. The Surveyor asked, is this the expectation of staff while feeding the residents; DON staff #2 stated No, that is not the expectation, staff should always be seated while feeding the resident.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews and staff interviews, it was determined that the facility failed to ensure the accuracy of the resident's Minimum Data Set (MDS). This was evident for 1 resident (Resident #3) out of 10 residents reviewed during the recertification survey.On 01/06/2026 at 1:06 PM, the surveyor reviewed Resident # 3's medical records. The resident record review revealed that, according to Resident # 3's January 2026 Medication Administration Record and current medication orders, Resident #3 did not receive insulin. It was documented in Resident #3's January 2026 Medication Administration Record and current medication orders that Resident #3 received a 50 mg tablet of Januvia, an oral anti-diabetic medication, each morning for type 2 diabetes.On 01/06/2026 at 1:32 PM, the surveyor asked the Assistant Director of Nursing staff #18 if Resident #3 received insulin. During the interview, staff #18 stated that Resident #3 did not receive insulin, and that Resident #3 received Januvia.On 01/06/2026 at 1:45 PM, the surveyor reviewed the resident's records. The resident record review revealed that, in the MDS, which has an ARD/Target date of 12/19/25, it is documented in Section N - Medications under N0350. Insulin, that Resident #3 received one insulin injection during the last 7 days or since admission/entry.On 01/08/2026 at 10:23 AM, the surveyor reviewed the resident's records. The resident record review revealed that, according to Resident # 3's discontinued medication orders, Resident #3 did not have any discontinued medication orders for insulin since being admitted to the facility on [DATE].On 01/08/2026 at 10:31 AM, the surveyor interviewed the Director of Nursing staff #2. During interview, the surveyor made staff #2 aware of the MDS discrepancy. Staff #2 agreed with the surveyor and stated that the MDS is wrong because Resident #3 did not receive insulin.

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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 review of resident medical records, observation and interviews, it was determined that the facility failed to perform appropriate revisions to resident care plan. This was evident for 1 resident (Resident #5) out of 10 residents reviewed during the survey. The findings include: Review of Resident #5's medical record on 01/08/2026 at 8:30 AM revealed a care plan with a problem area created on 08/04/2022, revised on 11/14/2025 stating that Resident #5 was an Elopement Risk with an approach to apply wanderguard: check placement Q shift and function Q Day. Further review of Resident #5's medical record revealed a Wandering Risk Scale - V3 assessment performed on 11/17/2025 with a score of 3 indicating that Resident #5 was a low risk of wandering. During observation rounds on 01/08/2026 at 9:15 AM Resident #5 was observed not wearing a wanderguard. During an interview on 01/08/2026 at approximately 10:10 AM the Director of Nursing confirmed and stated, [Resident #5's] current care plan was incorrect and needs to be updated, [Resident #5] is not a wander risk and should not be wearing a wanderguard.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews and review of facility documentation, the facility failed to properly store medications, biologicals and resident food items under proper temperature controls. This was evident for 2 out of the 4 medication, biologicals and resident food refrigerators observed during the annual survey. The findings include the following: During observation rounds, interview and review of facility documentation of the 3rd floor medication and resident food storage rooms on 01/07/2026 at 10:26 AM with staff # 4, refrigerator #1 was found to have several resident's food items. On the outside of this refrigerator was a Refrigerator Temperature Form for the month of January 2026 stating that temperatures must be between 38 and 42 degrees. On 01/07/2026 at 05:00 AM staff recorded that the refrigerator was 45 degrees Celsius. At the time of the observation the refrigerator reading was 45 Fahrenheit. A second refrigerator #2 was found to have several medications and biologicals for facility residents. On the outside of this refrigerator was a Refrigerator Temperature Form for the month of January 2026 stating that temperatures must be between 38 and 42 degrees. On 01/07/2026 at 01:00 AM staff recorded that the refrigerator was 20 degrees Celsius. Staff #4 stated, I will report this right now to the supervisor and confirmed reading of refrigerator #1 as well as the documented refrigerator reading for 01/07/2026 for both refrigerators. During an interview on 01/07/2026 at approximately 11:15 AM staff #3 was made aware of the refrigerator temperature findings and stated, We will be updating the form to indicate the correct temperature parameters and get maintenance to look at the refrigerators.

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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 observation, record reviews and interviews, it was determined that the facility failed to implement infection control practices to ensure oxygen equipment was dated when put into use. This deficient practice was evident for 2 (resident #37 and #135) of 3 residents reviewed for oxygen equipment during the annual survey.The findings include: 1. On 1/5/25 at 8:05 AM, Resident #37 was observed with an oxygen setup. The humidifier bottle and oxygen tubing attached to the resident's oxygen concentrator were noted to be in use but were not dated. At that time, the surveyor located Staff #4, who was identified as responsible for the care of Resident #37. Staff #4 confirmed the humidifier bottle and tubing were in use and acknowledged that they were not dated as required. Staff #4 then obtained a new humidifier bottle and oxygen tubing, placed them on the resident's concentrator, and marked both with the date. At 10:52 AM, the Nursing Home Administrator and Director of Nursing were informed of the surveyor's findings. 2. 01/05/2026 at 9:23 AM during initial observation, resident #135 was observed with nasal cannula intact and receiving 2L O2; however, O2 tubing was not labeled. On 1/5/2026 at 10:51 AM during an interview with DON staff #2, Regional Nurse staff #3 and NHA staff #1, this Surveyor shared the findings of no label on the Oxygen tubing in use; DON staff stated, 'the expectation is for all tubing to be labeled'. On 01/08/2026 12:39 PM during record review, it revealed the resident had a current order for 'Oxygen via Nasal Cannula at 2 LPM, every shift for Maintain POX above 90% for 7 Days AND as needed for Maintain POX above 90%; ordered 1/3/2026'.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on administrative records reviews and interviews it was determined that the facility failed to document and ensure that geriatric nursing assistants' (GNAs) human resources and clinical education records reflected the required 12 hours of annual clinical training/in-services as required. This was evident to be true for 5 out of 5 (GNA # 15, #16, #17, #21, #22) geriatric nursing aide clinical education and human resources records reviewed during the survey.The findings include: On 01/08/2026 at approximately 09:36 AM the surveyor requested the human resources records of six employees from the DON that held the job descriptions of geriatric nursing assistants. On 01/08/2026 the following GNA human resources and clinical education records were reviewed by the surveyor at 11:00 AM on : GNA # 15, #16, #17, 321, and #22. On 01/08/2026 12:34 PM The surveyor interviewed the ADON regarding the evidence/documentation/compliance requirements related to the annual clinical education and training for geriatric nursing assistant staff. The ADON stated that the annual hands on clinical training is provided to all clinical staff in October each calendar year. Also, the ADON stated the facility does have HealthStream online clinical training for nursing staff as well, however the completion of the online clinical education annually is non mandated at the present time. On 01/08/2026 at 12:15 PM the ADON brought additional documents that were printed from HealthStream however, these documents did include topics such as behavioral health, dementia training, or managing resident with traumatic stress disorder for example. The ADON stated that the staff have been resistant to completing the educational requirements online and there are currently no disciplinary consequences.On 01/08/2026 at 12:04 PM, the ADON stated that she was unable to provide any additional proof that the 5 GNA s selected by the surveyor had received the required 12 hours of annual clinical training required by federal and state requirements. The facility failed to provide any additional documentation of compliance with the required annual 12 hours of continuing education for the five GNAs educational records reviewed prior to the exit conference.These concerns were reviewed during the exit conference with the administrator, DON, and the corporate regional staff present on 01/08/2026.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide resident's rooms that measured at least 80 square feet per resident in 77 of 77 multi-resident rooms. Rooms 100, 102, 103, 104, 105, 107, 108, 109, and 110, measured 150 square feet. Rooms 300, 325, 326, 327, 331, 332, 333, 334, 335, 336, 337, 338, 341, 342, 346, 400, 411, 412, 421, 423, 424, 425, 426, 431, 432, 433, 435, 436, 437, 438, 441, 442, 444, 446, 447, 500, 511, 512, 523, 524, 525, 527, 531, 532, 535, 536, 544, 545, 547, 600, 611, 612, 621, 622, 623, 624, 625, 626, 627, 631, 632, 633, 634, 635, 636, 637, 641 and 642 measured 155 square feet. This failure had the potential for residents not to have reasonable privacy or adequate space.The findings include:On 1/5/2026 at 10:51, the NHA staff #1 provided an untitled document letter from the Centers for Medicare & Medicaid Services (CMS) dated 10/11/2024 which indicated the facility requested a waiver for the residents' room that did not measure 80 Square feet per resident in multi resident bedrooms and the waiver was granted for the rooms as listed: Rooms 100, 102, 104, 105, 107, 108, 109, and 110, measured 150 square feet. Rooms 300, 325, 326, 327, 331, 332, 333, 334, 335, 336, 337, 338, 341, 342, 346, 400, 411, 412, 421, 423, 424, 425, 426, 427, 431, 432, 433, 435, 436, 437, 438, 441, 442, 444, 446, 447, 501, 511, 512, 523, 524, 525, 527, 531, 532, 535, 536, 544, 545, 547, 600, 611, 612, 621, 622, 623, 624, 625, 626, 627, 631, 632, 633, 634, 635, 636, 637, 641 and 642 measured 155 square feet.During Initial Pool Resident observations and interviews, none of the residents residing in these rooms voiced any concern regarding the size of their rooms.Rooms 100, 102, 103, 104, 105, 107, 108, 109, and 110, measured 150 square feet. Rooms 300, 325, 326, 327, 331, 332, 333, 334, 335, 336, 337, 338, 341, 342, 346, 400, 411, 412, 421, 423, 424, 425, 426, 431, 432, 433, 435, 436, 437, 438, 441, 442, 444, 446, 447, 500, 511, 512, 523, 524, 525, 527, 531, 532, 535, 536, 544, 545, 547, 600, 611, 612, 621, 622, 623, 624, 625, 626, 627, 631, 632, 633, 634, 635, 636, 637, 641 and 642 measured 155 square feet. The prior CMS approval letter had listed room [ROOM NUMBER] which does not exist and should have been room [ROOM NUMBER], which measures 155 square feet. During an interview on 1/8/2026 at 11:30 AM with DON staff #2, NHA staff #1 and Regional Nurse staff #3, this Surveyor notified the facility they would need to submit a Waiver request for the above rooms.