STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215244	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devlin Manor Nursing and Rehabilitation Center	10301 North East Christie Road Cumberland, MD 21502

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. (continued on next page)

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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(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	Based on interviews, record reviews, and facility policy review, it was determined the facility failed to report an allegation of misappropriation of property timely to the state survey agency for 1 (Resident #6) of 5 facility-reported incidents for allegations of abuse, neglect, and misappropriation of property. Specifically, Resident #6 alleged to have $230 missing in January 2025, and the facility did not report the allegation to the state agency until April 2025.Findings included:The facility's undated policy, titled, Abuse, Neglect, Exploitation, or Mistreatment, indicated, The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment, and misappropriation of a patient's/resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately.Resident #6's Face Sheet indicated the facility admitted the resident on 03/03/2022. According to the Face Sheet, the resident had a medical history that included diagnoses of congestive heart failure, type II diabetes mellitus, and acute respiratory failure with hypoxia.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/21/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A Facility Reported Incident Initial Report Form, dated 04/26/2025, indicated the facility was informed of the allegation of misappropriation on 01/15/2025 but did not notify the state survey agency until 04/26/2025. The facility submitted the required 5-day investigation report to the state agency on 05/01/2025, which was not compliant with the required timeframe. Further review indicated Resident #6 reported to the Social Worker (SW) that they were missing $225 on 01/15/2025, and it was unknown of the date and time the money went missing. Following the allegation, staff placed a lock on Resident #6's bedside dresser, and statements were obtained from the staff and the other residents on the hall with decision-making capacity. Staff searched for the money in January 2025 and again in April 2025 when the allegation was made, but that amount of money was not found. The facility was unable to substantiate whether the resident ever had that amount of money.During an interview on 09/09/2025 at 9:57 AM, Geriatric Nursing Assistant (GNA) #5 stated that in January 2025, Resident #6 asked her to look in the resident's bedside drawer for money because the resident wanted to order some food. Per GNA #5, she looked in the resident's drawer, but there was no money there. GNA #5 asked the resident how much money was supposed to be there, and the resident stated $300. GNA #5 then stated she searched the resident's room but did not find the missing money, so she reported it to the nurse, who then searched the resident's room but did not find the money. The missing money was then reported to the Director of Nursing (DON). GNA #5 further stated she never knew Resident #6 to have that sum of money, but following the allegation, the facility provided the resident with a lock box for their valuables.During an interview on 09/09/2025 at 1:31 PM, the Social Worker (SW) stated Resident #6 reported money missing on 01/15/2025, but staff could never confirm the resident ever had the money. Following the allegation, the facility provided the resident with a lock box for valuables, but the resident never locked the drawer. The SW further stated they disregarded the allegation in January 2025 because no staff saw the resident with a large amount of money. Per the SW, the allegation related to missing money came up again in April 2025, so the facility chose to report the allegation to the state agency.During an interview on 09/09/2025 at 2:11 PM, Unit Manager (UM) #15 stated Resident #6 alleged to have money missing in January 2025 and staff checked the resident's room thoroughly without finding the money. Staff then placed a lock box in Resident #6's bedside table, but the resident never locked up their valuables. UM #15 further stated staff were not aware of Resident #6 having the amount of money they claimed was missing. Per UM #15, when Resident #6 expired, staff cleaned out their belongings and did find money in their lock box. Staff inventoried the resident's belongings and passed them on to their power of attorney (POA).During an interview on 09/09/2025 at 2:45 PM, UM #17 stated she did the state reportable related to Resident #6's missing money. Per UM #17, she received a call from compliance notifying her of Resident #6's missing money not being addressed, so she called her nursing consultant, who instructed her to report the allegation to the state agency. UM #17 further stated that after Resident #6 expired, staff found around $300 throughout their room. Staff inventoried the resident's belongings and gave them to the SW, who then gave them to the resident's family.During an interview on 09/10/2025 at 11:25 AM, the DON stated that in January 2025, Resident #6 alleged they were missing money, but staff were unable to determine if the resident ever had the amount of money they alleged

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, record review, facility document review, and facility policy review, the facility failed to timely assess and implement interventions after a change of condition for 2 (Resident #2 and Resident #4) of 3 residents reviewed for change of condition. The failure resulted in a delay of assessment and treatment for Resident #2 and Resident #4. Findings included: A facility policy titled, Physician and Other Communication/Change in Condition, revised 05/05/2023, specified To improve communication between physicians and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition. The policy also indicated, The nurse will document all assessments and changes in the patient's/resident's condition in the medical record. Changes and new approaches will be reflected in the individualized care plan. 1. A Resident Face Sheet indicated the facility admitted Resident #2 on 03/01/2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of dementia with mood disturbance and stiffness to the left and right shoulder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/07/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent for toileting hygiene and substantial/maximal assistance to roll left and right while in bed. Resident #2's Care Plan included a problem area, start date 04/26/2025 and edited 09/02/2025, that indicated the resident required assistance with activities of daily living (ADLs). Interventions indicated the resident required extensive assistance with bed mobility. Resident #2's Progress Notes dated 08/30/2025 revealed Registered Nurse (RN) #21 was notified by the resident's family that the resident had a cut on their hand. The note indicated RN #21 observed a deep laceration between the resident's right thumb and index finger approximately one inch wide. The note indicated the Certified Registered Nurse Practitioner (CRNP) was in the facility and assessed the resident and determined the resident needed to be sent to the emergency department for sutures. The note indicated the resident was transported to the hospital around 4:50 PM. Resident #2's Progress Notes by the CRNP dated 08/30/2025 revealed the resident had an open three-centimeter laceration wound to the skin of the right hand between the thumb and fourth finger with no active bleeding observed. The progress note indicated the wound was cleansed with normal saline and a dressing secured with gauze wrap was applied. The note indicated that the resident was transferred to the emergency department via emergency services for further evaluation and treatment of the right-hand laceration wound. Resident #2's Progress Notes dated 08/31/2025 indicated the resident returned to the facility with six sutures in place to the right hand between the thumb and index finger. Resident #2's Patient/Resident Incident/Accident Investigation Worksheet dated 08/30/2025 at 4:20 PM indicated the resident had a deep one-inch laceration between the right thumb and index finger. The investigation indicated the resident stated they were holding onto the side rail when staff tried to roll them. The investigation indicated the resident was sent to the emergency department for sutures, and the side rails were removed. Review of a witness statement of Geriatric Nursing Assistant (GNA) #7 obtained via telephone by the Director of Nursing (DON) dated 08/20/2025 revealed that when she came in for her shift, GNA #23 and GNA #8 gave her report and let her know that Resident #2 had sustained a skin tear to the resident's right hand during care. The statement indicated that when GNA #7 was providing care, they did not notice any bleeding to the resident's right hand on the first rounds but did notice dried blood in between the resident's right thumb and right index finger during her second rounds. Review of a witness statement of GNA #23 obtained via telephone by the DON dated 09/01/2025, revealed that while she was providing care for Resident #2 with GNA #8, the GNAs were turning the resident using a draw sheet, and the resident reached back and grabbed the side rail. The statement indicated they stopped turning the resident and noticed blood to the resident's right hand. The statement indicated they washed the blood off, placed a wet washcloth to the area, and told Licensed Practical Nurse (LPN) #22. Review of a witness statement of GNA #8 obtained via telephone by the DON, dated 08/30/2025, revealed that while she was providing care to Resident #2 with GNA #23, the GNAs were turning the resident with a draw sheet, and the resident tried to hit them and grabbed hold of the side rail. The statement indicated the resident sustained a skin tear to their right hand, and GNA #23 told LPN #22 about the incident. During an interview on 09/09/2025 at 10:26 AM, GNA #7 stated she came into work and got report from GNA #23 and GNA #8. She stated they told her that