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	03/20/2026

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 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. Based on record review and interview, it was determined that the facility failed to ensure their residents were free from abuse. This was evident for 1 of 2 residents reviewed for abuse.The facility implemented effective and thorough corrective measures following this incident prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 1/23/26.The findings include:MDS (Minimum Data Set) - is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A medical record review on 3/19/26 at 9:50 AM for Resident #4 (R4) revealed a Minimum Data Set (MDS) that documented the resident had no behaviors, severe cognitive impairment, unclear speech, and s/he understood what was being said sometimes. Furthermore, it was documented that the resident relied on staff to provide most ADLs (activities of daily living include but are not limited to the following: bathing, dressing, eating, and toileting). On 3/19/26 at 10:01 AM a review of the facility's investigation file for the facility reported incident #2726923 revealed the initial report form. Review of the form revealed that on 1/21/26 Geriatric Nursing Assistant (GNA) #6 reported to the Director of Nursing (DON) that she heard GNA #3 report to the oncoming dayshift GNA that R4 had hit her and she stated, fucked [his/her] ass straight up and [his/her] is a fucking retarded gimp Further stating that s/he will be nice now because s/he realized which one it was and s/he won't be getting any more ice cream from her. Review of the interview the DON had with Certified Medicine Aide (CMA) #5 revealed on 1/20/26, during the evening shift, she was in the hallway at the medicine cart near R6's room where GNA #3 and GNA #4 were putting the resident back in bed. She stated she heard GNA #3 state, don't fucking hit me. The statement read that she reported the door to the R6's room was closed so she could not see what was going on. Review of the interview that the DON had with GNA #4 revealed she confirmed she was assisting GNA #3 with putting R6 back to bed on 1/20/26 with the mechanical lift. She stated that GNA #3's voice was raised during the incident, but she could not remember if she cursed at the resident. Review of an interview that the DON had with GNA #3 revealed that R6 hit her and she held his/her arm down. The DON had not asked GNA #3 what she said to the resident. Further review revealed evidence that GNA #3 was terminated and when she was told she was terminated she admitted to cursing at R6. Evidence showed she was reported to the state licensing agency. Review of the education provided revealed that all facility staff were educated on Abuse Prevention, Recognizing, and Reporting. A mitigation plan for staff failing to report allegations of abuse timely was initiated on 1/21/26. On 3/20/26 at 9:30 AM reviewed the staffing assignment sheets for 1/20/26 and 1/21/26 which revealed GNA #3 worked evening shift starting at 2:30 PM on 1/20/26 and continued to work until 1/21/26 at 6:30 AM. This was confirmed by reviewing GNA #3's time punches for those days. On 3/19/26 at 10:55 AM the surveyor attempted to interview GNA #3 by phone and was unsuccessful. On 3/19/26 at 10:59 AM the surveyor attempted to interview GNA #4 by phone but was unsuccessful. During an interview with CMA #5 on 3/19/26 at 3:15 PM revealed that on 1/20/26 around 8 - 8:30 PM she was standing at her medication cart near R6's room. She stated (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

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	03/20/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that GNA #3 and GNA #4 were getting R6 out of his/her wheelchair in the hallway with the mechanical lift. She had her back to them, but overheard GNA #3 state, Don't fucking hit me. She reported she failed to report the abuse because she thought GNA #3 said this to GNA #4 and not to the resident. On 3/19/26 at 11:42 AM the concerns were reviewed with the DON. She stated that she determined it was abuse and implemented the following plan of correction: the employee was terminated and reported to the state licensing agency, and education on recognizing and reporting abuse was provided to all staff in the facility. A mitigation action plan was developed and implemented to follow in their Quality Assurance and Performance Improvement committee. Based on the above actions taken by the facility and verified by surveyor on site, it was determined that the facility's deficient practice was past noncompliance with a compliance date of 1/23/26. Cross reference: F609 and F610

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	03/20/2026

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. Based on record review and interview, it was determined that staff failed to recognize and report allegations of abuse to the State Agency within the required timeframe. This was evident for 1 of 4 facility reported incidents reviewed.The findings include:On 3/19/26 at 10:01 AM a review of the facility's investigation file for the facility reported incident #2726923 revealed on the initial report form it was indicated that the Director of Nursing (DON) became aware of an allegation of abuse on 1/21/26 at 9:32 AM. However, further review of the investigation file revealed that GNA #3 verbally abused Resident #6 on 1/20/26 during the evening shift. It was witnessed by facility staff who failed to report the abuse. The email confirmation read the report was sent to the State Agency (SA) on 1/21/26 at 12:42 PM. An interview with Certified Medicine Aide (CMA) #5 on 3/19/26 at 3:15 PM revealed she was present when the abuse occurred and confirmed it was on 1/20/26 between 8:00 PM - 8:30 PM. The concerns were reviewed with the DON on 3/19/26 at 1:34 PM. She reported that she thought the 2-hour timeframe to report to the SA started when she was notified of the allegation of abuse. Cross reference: F600 and F610

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	03/20/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, it was determined that facility staff failed to that a staff member who was observed abusing a resident, no longer had access to vulnerable residents to ensure there was no further abuse. This was evident for 1 (#4) of 1 resident review for abuse.The findings include:A medical record review for Resident #6 (R6) on 3/19/26 at 9:50 AM revealed a minimum data set (MDS) with an assessment reference date of 12/18/25 that read the resident had a diagnosis of dementia and was severely cognitively impaired.During a review of the facility's investigation file for the facility reported incident #2726923 on 3/19/26 at 10:01 AM revealed that GNA #3 abuse Resident #6 (R6) on 1/20/26 during the evening shift. While GNA #3 and GNA #4 was putting the resident back to bed GNA #3 stated to the resident, Do not fucking hit me. However, facility staff failed to recognize the abuse, and it was not reported to the Director of Nursing (DON) until 1/21/26 at 9:32 AM. On 3/20/26 at 9:30 AM staff assignment sheets for 1/20/26 and 1/21/26 were reviewed. Based on these documents GNA #3 worked evening shift starting at 2:30 PM on 1/20/26 and continued to work until 1/21/26 at 6:30 AM. This was confirmed by reviewing GNA #3's time punches for those days. An interview with Certified Medicine Aide (CMA) #5 on 3/19/26 at 3:15 PM revealed she was present when the abuse occurred and confirmed it was on 1/20/26 between 8:00 PM - 8:30 PM. This confirms that GNA #3 worked approximately 10 hours with vulnerable residents after she was overheard verbally abusing resident #6. The concerns were reviewed with the DON on 3/19/26 at 1:34 PM. Cross reference: F600 and F609

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	03/20/2026

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 0711 Level of Harm - Actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record review and interview, it was determined that the facility staff failed to monitor a resident with abnormal lab findings. The failure to do so, resulted in harm to the resident since the resident had to be hospitalized for treatment. This was evident for 1 (#6) of 2 residents reviewed for quality of care. The findings include:Cirrhosis of the liver is a condition in which the liver becomes scarred and unable to work properly. Ascites is a complication in which the liver does not produce protein in the blood causing fluid to build up in the abdominal cavity and if left untreated it can cause the resident to have trouble breathing. Esophageal varices is a complication that is caused by increased pressure in the portal (liver) vein that results in weak blood vessels in the esophagus. These weak blood vessels bleed easily and are the cause of 1/3rd of the deaths from cirrhosis. Lastly, with endstage liver disease, the liver cannot rid the body of waste and allows ammonia to build up in the blood. The high ammonia levels cause hepatic encephalopathy as evidenced by changes in behaviors, agitation, combativeness, irrationality, and muscle tremors. If left untreated a hepatic coma occurs which has a mortality rate of 90%. (Gerontologic Nursing, 7th Edition 2025). On 3/17/26 at 9:36 AM a medical record review for Resident #6 (R6) revealed a progress note dated 2/9/26 at 1:22 PM that read the resident's cancer center appointment was cancelled for tomorrow and to continue with the nurse practitioner's (NP) order for labs which included an ammonia level. A visit conducted by the attending physician on 2/10/26 revealed the resident the following but not limited to diagnoses: pancreatic cancer and cirrhosis of the liver with ascites and esophageal varices. A review of the lab results for the ammonia level drawn on 2/11/26 revealed the ammonia level was 76 with a reference range of 9-35, next to the results was a (H) indicating that the level was high. The result was circled and NNO (no new orders) written next to it. Above it was handwritten that there was no previous ammonia level. It was signed by Physician Assistant (PA) #1. A review of the progress notes and orders confirmed that PA #1 had not ordered any treatment or monitoring for the high ammonia level. Furthermore, there was no corresponding progress note. A progress note dated 2/18/26 revealed the resident was sent to the emergency department (ED) for further evaluation due to the resident's family member insisting that the resident was sent. A review of R6's acute hospital records on 3/19/26 at 12:06 PM for the ED visit on 2/18/26 and the subsequent hospitalization revealed in the ED notes that the resident had a change in mental status and abdominal pain. An ammonia level was obtained on 2/18/26 and the results were 180 with a reference range of 9-35. The primary diagnosis was hepatic encephalopathy. R6 was treated with lactulose which causes the resident to get rid of the excess ammonia by having multiple bowel movements in a day. The resident spent 6 days in the hospital and was discharged on 2/24/26. The R6's attending physician, who was the facility's Medical Director was interviewed on 3/17/26 at 11:06 AM. He reported that the resident had an elevated ammonia level and PA #1 had missed it. He reported that on 2/18/26 the resident had an altered mental status and the family insisted that the resident was sent to the ED, for which he was glad because of the ammonia level. He stated that the family was not happy and rightly so. He reported that he had extensive conversations with the Nursing Home Administrator (NHA) and Director of Nursing (DON) regarding the medical error. He reported that he reported the error to the provider staffing agency that he and PA #1 work for. During an interview with PA #1 on 3/17026 at 1:55 PM she confirmed that she reviewed the ammonia level for R6 on 2/11/26 and had not written any orders and she was unable to find a previous ammonia level for the resident. When asked her rationale for no new orders, she reported that the resident did not have a history of hepatic encephalopathy and the nurses had not reported a change in mental status, so she decided not to treat the resident. She stated that she wrote no monitoring orders to assess the resident for a change in mental status because it was a normal part of nursing care. Furthermore, stated without a change in mental status she felt the resident did not need treatment. When asked if she had anyone had questioned her (continued on next page)

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	03/20/2026

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 0711 Level of Harm - Actual harm Residents Affected - Few	decision not to write any new orders related to the ammonia levels. She stated that she had a meeting with her boss, who told her that her rationale was well thought out. The concerns were reviewed with the NHA and DON on 3/18/26 at 10:05 AM. When asked what the facility had done when the Medical Director had reported the concern to them. The DON mentioned that they had an action plan to address lab results. However, she admitted that it was a plan to ensure the facility received results in a timely manner which was not the concern with this incident. The DON reported that the staffing agency that contracted PA #1 had initiated a performance improvement plan (PIP) for the error. However, they had not conducted a root cause and analysis and implemented intervention to ensure the deficient practice did not occur again. An interview with the Medical Director of the staffing agency that contracted PA #1 on 3/18/26 at 11:14 AM revealed what he found throughout his investigation of the incident. He reported that PA #1 provided a written explanation of her rationale to not take action when she received the lab results. According to the MD, she had reviewed the resident's medical record and found that the resident was having 2-3 large bowel movements a day. She decided against treatment with lactulose because the goal of this treatment was to make the patient have 2-3 bowel movements a day and that was already occurring. He reported that she wrote in her statement that she planned to recheck the ammonia level in a couple of days, but failed to enter the order in the resident's medical record. The failure to write this order caused harm to the resident by resulting in 6 days of hospitalization.

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	03/20/2026

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 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 record review and interview, it was determined that facility staff failed to ensure that a resident had the medications they needed upon admission and throughout their stay. This was evident for 1 (#6) of 2 residents reviewed for quality of care concerns.The findings include:A medical record review on 3/17/26 at 9:36 AM for Resident #6 (R6) revealed the discharge summary from the hospital for 11/25. According to the record the resident had cancer of the pancreas (an organ that secretes enzymes to assist with digestion and absorption of nutrients) and had a Whipple procedure (a procedure in which the head of the pancreas, the first part of the small intestines, the gallbladder and the bile duct is removed) to treat the cancer. Further review of the discharge summary revealed the resident was on Creon, which was a medication with three pancreatic enzymes to assist with digestion and absorption of nutrients and was usually taken with every meal. A review of the resident's orders revealed the resident was ordered Creon 24,000-76,000-120,000 unit; administer 1 capsule by mouth 3 times a day on 11/19/25. A review of the medication administration record (MAR) for November 2025 revealed facility staff were to administer Creon to the resident at 8:00 AM, 12:00 PM, and 5:00 PM every day. According to the record the resident was not given the medication on 11/19/25 at 5:00 PM and the nurse noted the drug was not available from the pharmacy and was pending an evaluation from the attending physician to be ordered from the pharmacy. A review of the MAR for January 2026 revealed the resident was not administered the Creon on 1/7/26 at 12:00 PM and 5:00 PM and the nurse noted that the medication was not available to give. A review of the MAR for February 2026 revealed the resident did not receive Creon on 2/16/26 at 5:00 PM or on 2/17/26 at 8:00 AM, 12:00 PM, and 5:00 PM. The nurses noted each time that the medication was on order from the pharmacy. On 3/17/26 at 3:40 PM a review of the information sent from the pharmacy regarding how much Creon they had dispensed for the resident and when revealed the following: on 11/24/25 (5 days after admission) they sent 100 capsules, on 1/8/26 they sent 100 capsules, and on 2/17/26 they sent 100 capsules. These dates coincide with the dates that the resident had missed doses of the medication because facility staff allowed it to run out before the next order arrived. An interview with the Director of Nursing (DON) on 3/18/26 at 12:15 PM revealed she reviewed most new admissions. She reported she reviewed R6 prior to admission and gave the ok to admit the resident. She reported she was aware the resident was on Creon and acknowledged the importance of the medication to be taken with each meal. When asked why she had not ensured the facility had the medication to administer to the resident upon admission, she reported that they asked the family to provide the medication until they can get it in. She further explained that this medication required her signature to order and because it was not in stock at the pharmacy it took longer to get it in. She agreed that it was not the responsibility of the resident and/or family to provide medications that the resident needed in the facility. She was asked to provide evidence that family were asked to bring the medication upon admission by the hospital case manager. A review of the facility's Ordering and Receiving Medications from the Pharmacy policy and procedure on 3/18/26 at 12:30 PM revealed there was no implementation date noted. In addition, there were no provisions for special order medications included.On 3/18/26 at 1:03 PM an interview with Registered Nurse (RN) #2 revealed she was assigned to R6 the day that s/he was admitted . She stated that she was unable to administer the Creon because it had not been ordered from the pharmacy. She reported she called the DON and asked what she needed to do. She reported she was given the directive to call the resident's family and asked them to bring the medication from home. She stated that the DON told her that the attending physician needed to evaluate the resident to ensure if s/he needed the medication. (This was why she noted that on MAR on 11/19/25 for the missed 5:00 PM dose. She reported that resident's family brought the medication in the next day.During a subsequent interview with the DON on 3/19/26 at 1:34 PM. She reported she was unable to provide evidence that the case manager at (continued on next page)

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	03/20/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hospital had spoken to the resident and/or family regarding the need to bring the medication with them. She reported she consulted with the admission Coordinator too. She stated that even though they knew it took longer to get special order medications from the pharmacy, they had no process in place to order the medications prior to admission, so it was available when the resident arrived. Reviewed the days that the resident had missed doses because the refills had not arrived. She reported that there was no provision in place to ensure that refills were received before the pills ran out. She acknowledged the concerns and reported that she was going to implement provisions to have the medications ordered prior to admission and to order them 7 days in advance when they needed reordered.