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	03/27/2026

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and staff interviews, it was determined that facility staff failed to 1) ensure advance directives and decision-making authority were established and maintained for a resident who lacks decision making capacity and 2) document that residents were informed of their right to formulate Advance Directives upon admission. This deficient practice was evident for 4 (Resident #4, #1, #10 and #11) of 4 residents reviewed for Advance Directives during the annual survey. The findings include: 1) On 03/25/26 at 9:40 AM, a review of Resident #4's medical record indicated the resident lacked decision making capacity at the time of admission in March 2024. The resident's medical record failed to show evidence the facility obtained documentation of an authorized decision-maker, including advance directive for the resident. During an interview with the Director of Social Services (DSS) #14 on 03/25/26 at 10:15 AM, she reported that the resident's family member had been making decisions since 2024; however, no legal documentation was present to support the family member's authority. On 03/25/2026 at 10:34 AM, the DSS #14 reported that no documentation exists showing attempts made by the facility to establish a authorized decision-maker or to ensure completion of advance directive document from admission through 03/23/2026. 2) On 03/24/25 at 10:45 AM, a review of the residents' electronic records revealed Maryland Orders for Life Sustaining Treatment (MOLST) were completed as follows: Resident #1 MOLST completed on 02/24/26. Resident #10 MOLST completed on 06/11/24. Resident #11 MOLST completed on 09/09/25. The records failed to reveal that Advance Directives were discussed with residents and/or responsible representatives. On 03/24/26 at 10:45 AM during an interview the Director of Social Services reviewed the clinical records of Residents #1, #10 and #11 and reported that she could not find documentation to indicate that information on Advance Directive was discussed with the residents and/or responsible representatives.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to process and store linens in a manner to maintain infection prevention. This was evident during 1 of 1 observation of the laundry room during an annual survey.The findings include:On 03/24/26 at 9:02 AM, an observation of the hallway by the clean and dirty laundry rooms revealed two uncovered clothing racks which appeared to be full of resident linen.At the same time, further observation of the hallway revealed a room which had a singular washer and dryer next to one another. Further observation of the room revealed an uncovered clothing rack labeled, unlabeled clothing, and a medium sized basket on the floor of various rags/cloths.On 03/24/26 at 9:03 AM, an interview with Housekeeping Aide (Staff #16) revealed that only resident linen was washed, dried, and sorted in the room where there was a singular washer and dryer. She further indicated they have separate clean and dirty laundry rooms for bed linen, towels, and other items other than resident clothing. During the same interview, the surveyor asked Staff #16 what the basket of rags/cloths were on the floor in the room and she indicated they were from the kitchen and also get cleaned in the room that was indicated to only be used for resident clothing/linen. On 03/24/26 at 9:05 AM, further interview with Staff #16 revealed that clean resident clothes were sorted in the resident clothing laundry room and hung up on the rack outside in the hallway. On 03/24/26 at 9:06 AM, an interview with Housekeeping Director (Staff #17) regarding the separate clean and dirty laundry rooms, as well as the resident clothing specific room, revealed it was the only facility she knew of that processed linens as such. During the same interview, she confirmed that resident clothing gets processed (dirty resident clothing gets washed and clean resident clothing gets dried and sorted) in the resident clothing only room, and that bed linens, towels, and other items were processed in the clean and dirty laundry rooms. She further indicated that the facility has no room for the clean resident clothing racks and that was why they were out in the hallway.On 03/27/26 at approximately 9:30 AM, the surveyor reviewed the concern with the Nursing Home Administrator. He indicated that he understood and that the exposed clean resident clothing rack had since been moved after surveyor intervention.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that facility staff failed to make sure a legal decision maker was in place for a resident in a timely manner. This deficient practice was evident for one resident (Resident #4) reviewed for decision making capacity during the annual survey.The findings include:On 03/25/26 at 9:40 AM, a review of Resident #4's medical record revealed an admission date of 03/06/2024, with multiple diagnoses, including dementia. Further review indicated that no advance directives were documented for the resident. On 05/31/2024, the attending physician, and on 06/03/24 the nurse practitioner, certified that Resident #4 lacked decision making capacity. The medical records failed to show evidence of a court appointed legal healthcare decision maker.On 03/25/26 at 10:15 AM, during an interview, the Director of Social [NAME] (DSS) #14 stated that when a resident is admitted without decision-making capacity, the facility contacts the resident's family and advises them to seek legal guidance to establish a decision maker. The surveyor inquired about Resident #4's appointed decision maker. The DSS #14 stated she was unsure whether the facility had obtained the required documentation but reported that the facility was currently in the process of obtaining guardianship. The surveyor requested that the DSS review the medical records to determine whether documentation of a court appointed decision maker was present and to provide any available guardianship documents.On 03/25/2026 at 10:34 AM, the DSS #14 provided the surveyor with a progress note dated 03/23/2026 at 1:25PM, which indicated that certification for guardianship had been submitted to the physician and provider for completion. The DSS #14 further stated that the facility did not have documentation of any prior attempts to obtain an appointed healthcare decision maker since the resident's admission in 2024.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on resident record review and staff interview, it was determined that the facility failed to conduct a comprehensive Minimum Data Set (MDS) assessment within 14 days of a significant change. This was evident for 1 (Resident #52) of 3 residents reviewed during the annual re-certification survey.The findings included:On 03/23/26 at 10:28 AM, during the initial observation, Resident #52 was observed lying in bed on her back and her left hand was contracted.On 3/25/26 at 7:38 AM, Resident #52's medical records were reviewed and revealed that Physical Therapy (PT) assessed contractures of her right and left ankle upon their admission assessment on 3/1/23.Occupational Therapy (OT) notes revealed Resident #52 had contracture of muscle in their left hand on 4/26/24.The MDS assessments were then reviewed and revealed that in section GG functional limitation in range of motion on 6/7/2024, 9/5/2024, and 12/6/24, the upper extremities (shoulder, elbow, wrist, and hand) were documented as no impairment, even though Resident #52 was being treated by OT for left hand contraction since 4/26/24.On 03/25/26 at 2:05 PM, the Director of Nursing (DON) was interviewed because the MDS nurse was on vacation. The DON was shown the OT progress notes from 4/26/24 and the MDS assessments for 6/7/24, 9/5/24, and 12/6/24, which documented that Resident #52 had no upper extremity impairment when her left hand was contracted since April 2024.The DON acknowledged that the MDS documentation regarding Resident #52's left hand being contracted was a significant change and should have been documented timely.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility staff failed to develop a 48-hour baseline care plan upon admission. This was evident for 1 (Resident # 106) of 20 residents reviewed for care plans during the annual re-certification survey.The findings include: On 03/24/26 at 1:53 PM Resident #106 medical records were reviewed and revealed that Resident #106 was admitted to the facility on [DATE]. The baseline care plan could not be found in the Matrix, the facilities electronic health records (EHR).On 03/24/26 at 2:43 PM Staff #5, the Regional Clinical Director of Nursing (CDON) was asked to provide a copy of Resident #106's 48-hour baseline care plan.On 03/24/26 at 2:58 PM Staff #2, the Director of Nursing (DON) and Staff #5 CDON were interviewed and asked if they had documentation that Resident #106's 48-hour base line care plan was completed. The DON stated that they did not do the 48-hour care plan for Resident #106. Both the DON and the CDON verbalized understanding that the base line care plan should have been completed within 48 hours of Resident #106's admission.

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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 observations, staff interviews, and record review, it was determined that the facility staff failed to revise the comprehensive care plan to reflect the resident's need for oxygen therapy. This deficient practice was evident for one (Resident #19) resident reviewed for care plans during the annual survey.The findings include:On 03/23/2026 and 03/24/2026, the surveyor observed Resident #19 in bed receiving oxygen at 2 liters via nasal cannula.A review of the resident's comprehensive care plan failed to include the use of oxygen therapy, monitoring, or interventions related to respiratory needs.On 03/24/2026, during an interview, the Director of Nursing (DON) acknowledged that the care plan should have been updated to reflect the resident's oxygen use following the hospitalization in October 2025 and November 2025.A review of the hospital discharge summaries dated October 2025 and November 2025 confirmed ongoing oxygen therapy needs; however, the care plan was not updated to reflect these changes in condition.

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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 observations, staff interviews, and record review, it was determined that the facility failed to ensure physician orders were obtained and implemented for oxygen therapy. This deficient practice was evident for one resident (Resident #19) reviewed for professional standard of practice during the annual survey.The findings include:On 03/23/2026 and 03/24/2026, the surveyor observed Resident #19 in bed receiving oxygen at 2 liters via nasal cannula.On 03/24/2026, during an interview, the Registered Nurse (RN) #12 confirmed the resident was receiving oxygen. Both the surveyor and RN #12 reviewed the resident's medical record which failed to reveal an order for oxygen. The RN acknowledged the order was missing and stated the resident should have an oxygen order.A review of the resident's hospital discharge documents dated October 2025 indicated the resident was to be weaned to 1 liter of oxygen, and hospital discharge documents dated November 2025, indicated a history of hypoxia (low oxygen) requiring 3 liters of oxygen via nasal cannula.On 03/24/2026, the Director of Nursing (DON) stated, the admitting nurses are responsible for copying hospital discharge orders into the facility system. She acknowledged that Resident #19 was hospitalized in October 2025 and November 2025 and returned on oxygen; however, the admitting nurse failed to enter an oxygen order upon readmission.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review and interviews, it was determined that the facility failed to ensure that a dependent resident's grooming needs were met. This was evident in 1 (Resident# 10) of 1 resident reviewed for Activities of Daily Living (ADL).The findings include:On 03/23/26 at 11:36 AM the surveyor observed Resident #10 sitting at the side of his/her bed, with a disheveled appearance and facial hair about a quarter of an inch long.On 0/23/26 a review Resident #10's most recent MDS ARD 02/11/26 revealed a Brief Interview Mental (BIMS) score of 6 indicating severe cognitive impairment. A further review of the clinical record and care plans did not find evidence that the resident refused care, including shaving and grooming.On 03/23/26 at 2:28 PM in an interview GNA #19 stated that she was not assigned to the resident at the time of the interview, but she had a good relationship with the resident. She indicated that whenever she provided care the resident did not refuse grooming.On 03/24/26 at 1:10 PM the surveyor again observed the resident with unshaven facial hair sitting on his/her bed. The surveyor interviewed the Unit Manager #18 who accompanied the surveyor to the resident's room and confirmed the findings. On 03/24/2026 at 1:30 PM during an interview the Director of Nursing stated that she was made aware of the surveyor's concerns. However, Resident #10 sometimes refused care, but the refusal of care was not mentioned on the resident's care plans. She further stated that the Unit Manager was in the process of updating the resident's care plan.On 03/24/26 at 1:51 PM Unit Manager #18 reported to the surveyor that the resident's facial hair was shaved, and the care plan had been updated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, it was determined that facility staff failed to ensure effective communication by not addressing hearing impairment for a resident identified with hearing loss. This deficient practice was evident for one (Resident #82) resident of two residents reviewed for vision and hearing during the annual survey.The findings include:On 03/24/26 at 10:08 AM, during an interview with Resident #82, the resident reported difficulty hearing and asked the surveyor to stand on the left side of the bed since hearing is better with the left ear. The resident also reported they did not have hearing aids.Review of the care plan dated 02/06/2025 identified hearing loss and included interventions such as facing the resident and speaking clearly. A review of the minimum data set (MDS) dated [DATE] indicated minimal hearing difficulty. The most recent MDS dated [DATE] indicated a decline in hearing to moderate hearing difficulty. Further review of the medical record failed to show evidence of an audiology screening or evaluation.On 03/26/2026 at 10:04 AM, during an interview, the Director of Nursing (DON) confirmed that the resident has not been assessed for hearing loss and could not provide an explanation for lack of referral or evaluation.