STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215341	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Nsg & Rehab Ctr Belair	1909 Emorton Road Bel Air, MD 21015

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on record review and interview it was determined that the facility failed to allow residents the right to have a dignified existence by failing to answer call lights in a timely manner. This was evident for 3 (#30, #43, and #42) of 41 residents reviewed during the survey. The findings include: 1) A review of the facility reported incident #MD00193246 on 4/4/24 at 10:24 AM revealed Resident #30 had reported an allegation of abuse on 6/9/23 because when s/he put his/her call light staff had not responded. A review of the call light response times included in the investigation filed revealed that the resident had waited 30 - 50 minutes for staff to respond to his/her call light between the dates of 6/1/23 - 6/7/23. A review of Resident #30's medical record on 4/4/24 at 9:00 AM revealed an admission assessment dated , d+[DATE] that documented the resident was able to use the toilet for urination and bowel movements. The care plan for Activities of Daily Living (ADL - everyday task that people do to care for themselves, such as eating, toileting, bathing, dressing, etc.) initiated at the time of admission revealed the resident required at least 1 staff member to assist them to the restroom. In addition, the resident was to be toileted at specific times and as needed to promote the continuation of using the toilet. An interview with Resident #30 on 4/4/24 at 1:29 PM revealed that s/he had a stroke and lost the use of the left side of his/her body. The resident reported s/he needed the assistance of staff for toileting. The resident reported that they still use the toilet for bowel movements, but they do not always make it to the toilet for urination. Furthermore, the resident was concerned about urinary tract infections and skin problems from being in a wet brief for an extended period. An interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) revealed that in response to this incident that they identified call light response times were too long. They reported that their expectation was 10 - 15 minutes. The DON provided education to staff that call bell response time was with 10 minutes. However, they failed to continue to audit call lights and determine if the education was effective and staff were answering call lights in a timely manner. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 4/8/24 at 10:30 AM a review of complaint # MD00198476 revealed that an anonymous complaint had been reported to the State Agency (SA) that reported staff were not answering call lights in a timely manner. The complaint was filed on 10/19/23 and no specific residents had been named. A review of call bell response audits for 9/17/23 - 9/30/23 was conducted on 4/8/24 at 12:08 PM. The review revealed that residents were waiting 28 - 57 minutes for a call light response. On 4/8/24 a review of the facility's education on call light response times revealed that they had educated staff between 6/15/23 - 10/27/23 on call light response expectation. The expectation was a call light should be answered within 10 minutes and that other staff on the unit should answer the call lights for residents who were not assigned to them. In addition, on 9/11/23 an in-service was done for staff to encourage residents to use their call lights and that they should make sure the resident's needs have been met. However, the call light response times continued to be 28 - 57 minutes. On 4/9/24 at 8:17 AM, the concerns were reviewed with the Director of Nursing and Nursing Home Administrator. 3) On 4/8/24 at 10:41 AM a review of a grievance for Resident #42 revealed that on 3/4/24 during a care plan meeting, the resident complained of call light response times of an hour plus on dayshift during the week and weekends. The Director of Nursing (DON) responded that the resident's average call light response time was 13 minutes, and the longest time was 1 hour and 21 minutes with a few times it was in the range of 20-40 minutes. The response stated that staff were actively being trained on the expectations of call light response times, however this had been the 3rd training in the past year that was given to staff without success of correcting the issue. A review of the call light response times for Resident #42 the week prior to the complaint revealed the resident had waited 1 hour and 21 minutes for a response on 3/2/24 and early that day had waited 20 minutes. In addition, the resident had waited 43 minutes on 3/3/24 and 51 minutes on 3/5/24. 4) On 4/8/24 at 10:41 AM a review of a grievance for Resident #43 revealed that on 3/7/24 during a care plan meeting, the resident voiced concerns about the long call light response times. The resident reported that due to being on Lasix (a medication to get rid of excess fluid) caused him/her to have urinary urgency, but staff had not answered the call light in a timely manner. A review of those call light response times for Resident #43 the week prior to the complaint revealed that the resident had waited 19 - 50 minutes for staff to respond. The resident reported a urinary urgency and was subjected to waiting an extended period of time to have those needs met. An interview was conducted with the DON and NHA on 4/8/23 at 2:30 PM regarding the grievances filed by Resident #42 and Resident #43. The interview revealed that they had determined these residents had waited extended times for call lights responses, however they failed to investigate each of the extended times to determine the root cause of these long wait times. By failing to do this, they were unable to implement an appropriate corrective action. Cross Reference: F726

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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. 30428 Based on medical record review of a complaint and a facility reported incident, review of medical records and interview with staff, it was determined that the facility failed to ensure that a resident was free from mental and physical abuse. This was evident during the review of 2 of 23 (#21 and #22) residents reviewed for abuse. The findings include: Review of the facility reported incident #MD00196006 and related complaint #MD00196058 on 4/3/24 at 10:44 AM revealed a concern regarding GNA staff # 17. According to the incidents, GNA #17 on 8/24/23 Resident #21 reported that s/he used the call bell for assistance to use the bathroom. S/he reported that after a long time GNA #17 came in and threw the call bell at Resident #2. GNA #17 then yelled at Resident #21 not to press the button again. According to the investigation and report Resident #21 reported that s/he was fearful following that incident and would not use the call bell for the remainder of the shift for any assistance. Review of the medical record for Resident #21 on 4/5/24 at 9:00 AM revealed that s/he had mixed incontinence, meaning that s/he was able to use the bathroom room with assistance, however, did have times when s/he would be incontinent in a brief. Record review also revealed that /she had a brief interview of mental status of 12 out of 15 at the time of the incident. Meaning that s/he was moderately impaired. Surveyor interviewed Resident #21 on 4/5/24 at 8:12 AM. S/he was alert and oriented. S/he stated that now staff treat him/her very well and that his/her roommate look out for each other. S/he stated that that incident was terrible, and the staff was yelling at her and saying such inappropriate things to him/her. S/he went on to state that currently s/he feels safe and is happy with the care they receive. Further review of the incident reports revealed an additional incident on the same day of 8/24/23 with GNA #17 that occurred with Resident #22. According to the incident reports GNA #17 during activities of daily living (ADL) care for Resident #22 turned him/her 'roughly' enough that Resident #22 verbalized discomfort. His/her brief interview for mental status at the time was assessed as a '1,' suggesting severe cognitive impairment. Therefore, a physical assessment was completed based on the residents' outward expressions of discomfort and pain. Resident #22's right arm and shoulder were assessed and noted painful. An x-ray was ordered of the elbow, humerus, and forearm. The results were negative; however, the resident was medicated with Tylenol for pain. The facility determined based on the interviews and observations with an orientee that was with GNA #17 at the time of the incidents and interviews with the Resident # 21 that staff #17 had done what she was accused of by the residents and was removed from the facility and not allowed to return. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of GNA #17's employee file on 4/4/24 at 12:20 PM revealed that she had not completed her annual abuse training since 2020. The Director of Nursing (DON) and Administrator were interviewed on 4/4/24 at 12:25 PM regarding the surveyors' findings of the lack of abuse training and the findings related to the incident reports. The Administrator was not aware that the training was not completed but stated that the employee was reported to the Board of Nursing. The findings were reviewed throughout the survey and again during exit from the facility on 4/9/2024. cross reference F947

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40927 Based on record review and interview it was determined that the facility failed to conduct a thorough investigation of an allegation of neglect to determine the root cause and implement a plan of correction. This was evident for 1 (#30) of 23 residents review for abuse. The findings include: On 4/4/24 at 10:24 AM a review of the facility's investigation for facility reported incident # MD00193246 revealed that Resident #30 had reported an allegation of neglect on 6/9/23. The allegation stated that the resident felt neglected because staff do not respond to the call light. A review of the facility's call light audit revealed that during the 7 days that were reviewed the resident had waited 30 - 50 minutes for call light response. However, these extended wait times were during all 3 shifts. Further review of the investigation revealed that facility staff had interviewed each Geriatric Nursing Assistant (GNA) who had been assigned to the resident during the long call light response times. However, they failed to interview the nurses and other GNAs assigned to the unit to determined what they were doing during the times the resident had waited extended time. In addition, they failed to interview any residents who may have been affected. An interview on 4/4/24 at 2:09 PM with the Director of Nursing (DON) and Nursing Home Administrator (NHA) regarding the incident investigation was conducted. The DON reported that when they collected the statements from the GNAs that stated they had been providing care in another room. They were not sure if they had interviewed other staff assigned during those times. The DON stated she would check and report back, however by the end of the survey she had not provided evidence of any additional interviews. In response to this incident, they determined that staff needed to be educated regarding call bell response time expectations. The NHA and DON both agreed that a reasonable response time was within 15 minutes. DON and NHA reported they had not audited call bell response times following the education to determine if it had been effective. A review of the call bell response time audit for 7/1/23-7/7/23 revealed that residents continued to wait 30 minutes to 64 minutes for responses to call bells after the education had been given. On 4/8/24 at 2:30 PM the concerns were reviewed with the DON and NHA.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37586 Based on medical record review and interviews the facility failed to provide incontinent care for dependent residents. This was true for 2 out of 2 (resident # 6 and resident # 39) residents reviewed for Activities of Daily Living for dependent residents. Findings include: 1. A medical record review was conducted on 4/3/24 at 10:49 AM. Medical record revealed on 12/18/21, resident # 6 complained to the social worker about a GNA #21. The resident stated that GNA #21 changed him/her at 4 PM on 12/17/21. At 7 PM, resident called the GNA to change him/her again. GNA stated they would be right back but never showed up again. Resident was finally changed at 3 AM by the nurse staff # 4. On 12/19/21 GNA # 21 was called in to speak with the Administrator about the incident that took place with resident # 6 over the weekend. The nursing home administrator took GNA # 21 off the schedule for neglect and reported GNA #21 to the Board of Nursing. 2.On 4/5/24 at 8:26 AM a review of medical records indicated resident # 39 was admitted on [DATE] for rehab after a stay at the hospital. According to family, they came to visit Resident #39 every evening and found his/her brief soiled, which family cleaned up. Resident # 39 complained to family that he/she uses the call bell to ask for help to be changed but no one ever answers the call bell. Resident had a foley catheter due to urinary retention. A review of Resident #39 ' s kardex indicated that resident was not changed for bowel movements on the following days: day shift: 12/2/2021, 12/10, 12/11, 12/17, 12/18, 12/20, 12/22, and 12/24/21. Resident #39 also was did not receive incontinence care on the evening shift: 12/1/2021, 12/3/21, and 12/27/2021. There was no shower or bed bath given on 12/6/21, 12/10, 12/11, 12/17, 12/18, 12/20, 12/22, and 12/24/2021 on the day shift. Mobility in bed and dressing change was not documented on: 12/6/21, 12/10 and 12/11, 12/17, 12/18, 12/20, 12/22, 12/23, and 12/24/2021 on the day shift. The administrator and Director of Nursing were made aware of the missing documentation found in the Kardex. During that time the Administrator and Director of nursing were not working at the facility. (A GNA Kardex) Geriatric Nursing Assistant Kardex is a record of all the ADL Activities of daily Living that a GNA does for the resident)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37586 Based on medical chart review and interviews with the DON (Director of Nursing), the facility failed to ensure residents receive care, consistent with professional standards of practice, to prevent pressure ulcers. This was evident for 1(resident #39) out of 1 resident investigated for wounds. Findings include: On [DATE] at 8:26 AM a medical record review was completed for Resident #39, who was admitted to this facility for rehab therapy. When resident # 39 was admitted to the facility there were no wounds on their sacrum according to the admission assessment. On [DATE], a new open area was found on Resident 39's sacrum with a red wound bed; new orders were given for Splurge with Rotifer dressing daily. At the time the wound was discovered, nursing failed to obtain wound measurements for the new area on the sacrum. On [DATE], the wound was described as larger with foul smelling drainage and a dark brown in color. The surrounding area was red. There were still no measurements of the wound recorded. The physician ordered silver to treatment orders. Resident #39 was sent to the hospital on [DATE] for change in mental status and lethargy. An interview with the residents son on [DATE] at 9:56 AM, indicated resident died from sepsis and from sacral wound complications on [DATE] in the hospital. INterview_____

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 40927 Based on record review and staff interview it was determined that the facility failed to ensure that nursing assistants were competent and had the skill set needed to care for the residents. This was evident for 1 (#) of # nursing assistant staff reviewed. The findings include: On 4/8/24 at 9:48 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) present a review of Geriatric Nursing Assistant (GNA) Staff #22's employee file. There was no evidence that the facility had determined the level of competence of Staff #22 to ensure she had the skill set to care for the residents. The DON and NHA reported they would check and report back to the surveyor. On 4/8/24 at 2:30 PM the NHA and DON reported that there was no additional paperwork for Staff #22 other than what had been provided to the surveyor. The Human Resources Director was asked to provide Staff #22's hire date and termination date. On 4/9/24 at 7:15 AM the paperwork was provided and according to the hire letter Staff #22 was hired 10/2022 as a nursing assistant in training as she had not been issued her GNA certification until 5/2023. On 4/9/24 at 8:17 AM the concern was reviewed with the DON and NHA. Cross Reference: F550

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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. 30428 Based on the review of complaints, facility reported incidents, interviews, and employee files, it was determined that the facility failed to ensure that geriatric nursing assistants (GNA) had the required 1. abuse training and 2. competencies to provide safe and proper care to residents in the facility. This was determined during the review of 1 (GNA #17) of 9 employee files. The findings include: 1. Review of the employee file of staff GNA #17 on 4/4/24 at 12:20 PM revealed that she had not completed her annual abuse training since 2020. The Director of Nursing (DON) and Administrator were interviewed on 4/4/24 at 12:25 PM regarding the surveyors' findings of the lack of abuse training. They were not aware that the training was not up to date at that time, additionally, they were newly getting acclimated to the facility and had the employee immediately removed and reported to the board. The employee's file was reviewed secondary to allegations of abuse and neglect on 8/24/23. The Administrator and DON implemented education and inservices to the other employees related to the findings from the incidents that occurred on 8/24/23. The concerns were reviewed throughout the survey and again during exit on 4/9/24.