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	06/12/2024

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

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. 47200 Based on interview and record review it was determined the facility failed to ensure an allegation of neglect and an investigation of neglect were timely reported. This was evident for 1 (MD00205866) out of 6 facility reported incidents reviewed during the facility's recertification survey. The findings include: On 5/28/24 the surveyor began review of a facility reported incident (MD00205866). On 5/31/24 at approximately 10:27AM the surveyor conducted an interview with the facility Administrator who reported the following information regarding the facility's process for the reporting of allegations of abuse and neglect: Supervisors report to us and we act on and start investigation immediately, we talk to residents, we determine if it is something we need to report, determine if it is a care concern or a customer service issue, or something that looks like it could be abuse or neglect, and investigation along the lines of abuse is reported to OHCQ within 2 hours of us getting notified. On 5/31/24 at 12:41PM the surveyor observed the following documented in the facility's initial self report: On 5/9/24, the SW (Social Worker) made the DON/NHA (Nursing Home Administrator) aware that the resident was left lying flat in bed, uncovered and call bell was not within reach. Resident reported time was from around 8:30am to 1pm. Additionally, the surveyor noted the facility documented the allegation type was an investigation for neglect, the incident was alleged as occurring on 5/9/24, and was not initially reported to the Office of Healthcare Quality until 5/17/24 at 5:00PM, approximately eight days later, during which time, a second alleged incident of neglect of Resident #3 was documented as occurring beginning on 5/11/24. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 2:41PM the surveyor conducted an interview with the Director of Nursing (DON) and Administrator who confirmed the dates and times of submission of the reports, at which time, the surveyor shared their concerns. When the surveyor inquired as to why the allegation was not reported timely, the DON reported the incident didn't feel intentional. When the surveyor inquired to the Administrator, they reported the following: It was not as big of a gap of time as we were first told. It wasn't that long the resident was left, typical rounding should be every two hours, it was one hour beyond that, the resident didn't feel it was intentional. When the surveyor further inquired as to if intention had to be present in order to report the allegation, the Administrator replied: No, it's not that we think it has to be intentional, what does the policy say? It doesn't have to be intentional to report it. On 6/11/24 at 1:19PM the surveyor conducted an interview with Geriatric Nursing Assistant (GNA) #27, who was assigned to the care of the resident on 5/9/24. GNA #27 reported to the surveyor that when they entered the resident's room, s/he was on their side, and had been left from wound rounds and verbalized needing LPN #5 to do a dressing. GNA #27 further reported that on 5/9/24, Resident #3 stated the following to them in response to the incident: Wound rounds left me like this. At this time, GNA #27 confirmed with the surveyor that the resident was upset by the incident. GNA #27 confirmed they believed it had been several hours since the resident had been checked on last, and additionally reported, that after the incident, all parties involved were taken to the Director of Nursing's office where staff were asked if they understood the severity of the situation.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on complaint intake review, medical record review, and staff interview it was determined that the facility failed to document the transfer of a resident in the medical record including the reason for the transfer. This was evident for 1 (#166) of 3 residents reviewed for discharge. The Findings include: Resident #166's closed medical record was initially reviewed on 6/5/24, in relation to complaint intake MD00206001. Resident #166 was admitted to the facility on [DATE]. Per the census tab in the electronic health record (EHR) revealed the resident was discharged on [DATE]. There was not a discharge note to indicate the reason for the discharge, or information of how, or when the resident left the facility. Under the evaluations tab in the EHR was an in Progress discharge instructions document without indication as to who was provided the instructions. The Director of social services (staff #21) was interviewed on 6/5/24 at 1:30 PM. Upon identification of the resident in question she did a custom search of social work notes. She indicated that she could not remember the circumstance of the initiation for discharge, and she agreed that something should have been written. The social worker indicated that she may have some documentation in a soft file (personal file not in the medical record) and she would get back to the surveyor with any discovered information. On 6/6/24 at 10:16 AM the director of social services provided email documentation from March 2023 with indication the resident was issued a Notice of Medicare Non-Coverage (NOMNC) on 3/3/23 with indication of the discharge to occur on 3/6/23. The email documentation further indicated that resident #166 was granted an extra day with discharge set for 3/7/23. The social worker was informed of the concern that the medical record was absent and incomplete discharge documentation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47200 Based on interview and record review it was determined the facility failed to: 1) ensure timely and necessary care was provided to a resident, including following medical orders, staff communication regarding resident needs, oversight, assessment and action by staff trained and allowed within the scope of practice for care of resident tube feeding equipment and appropriate documentation of care concerns, and 2) ensure that there were accurate physician orders for resident care. This was evident upon surveyor's review of two facility self reported incidents (MD00205639 & MD00205866) regarding Resident #3, and one resident (Resident #71) of three residents reviewed for rehabilitation services. The findings include: 1.) On 5/28/24 the surveyor began review of two facility self-reported incidents concerning the care of Resident #3. On 6/3/24 at 12:55PM the surveyor conducted a review of the medical record which revealed the following care information for Resident #3 which included the following: turn and reposition every 2 hours and as needed while in bed, turn q2hr and PRN pillows- placement- repositioning, provide incontinence care every 2 hours and as needed, use barrier cream with incontinence care as indicated, side rails- observe for injury or entrapment related to side rail use, bed mobility- requires participation of 2 to reposition and turn in bed to prevent shearing, dependent on staff, prefers to re-position with 2 people, frequent repositioning, check enteral tube for residual every shift/if 150 ml or over, hold feeding for 1 hour and re-check: if residual 100ml or over, notify MD- document in ml- every shift document amount, provide water flush 300ml x 3 during tube feed time 4pm-5am every evening and night shift, enteral feeding via g-tube every shift via feeding pump at 60ml/hr x 13hrs total volume 780ml/24hr up at 4pm/down at 5am one time a day run tube feeding until total volume infused, safe environment- reachable call light, and call light within reach. On 5/30/24 at 1:05PM upon surveyor review of the initial self reports made by the facility it was noted that the facility documented the first incident concerning Resident #3 was alleged as having occurred on 5/9/24. On 5/30/24 at 1:05PM upon surveyor review of the initial self-reports made by the facility it was noted that the facility documented the second incident concerning the resident was alleged as having occurred on the 11pm-7am shift on 5/11/24 into 5/12/24. On 5/30/24 at 1:05PM, the Director of Nursing (DON) verbally confirmed with the survey team that the facility-reported incident investigation files presented to the surveyor were the complete investigation files for both incidents. During an interview on 5/31/24 at 2:52PM the DON and Administrator confirmed with the survey team that the list of times documented in the investigation files were complete from their review of camera footage of staff entering and exiting the room of Resident #3 during the alleged timeframes of the incidents and confirmed that their investigations relied upon this review and documented information. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 12:41PM the surveyor reviewed the facility's initial self report dated 5/9/24 which documented that the Social Worker made the facility's Director of Nursing and Administrator aware of an allegation involving Resident #3 on 5/9/23, having been left left lying flat in bed, uncovered without their call bell in reach for an extended period of time. The surveyor noted the incident was alleged as occurring on 5/9/24, and was not initially reported to the Office of Healthcare Quality until 5/17/24, approximately eight days later, during which time, a second alleged incident regarding Resident #3 was documented as occurring beginning on 5/11/24. Surveyor review of the facility's documented final self report for the 5/9/24 incident revealed the facility documented the outcome of the investigation was inconclusive, despite also documenting that it was determined that no staff rounded on the resident for three hours. On 6/11/24 at 1:19PM the surveyor conducted an interview with Geriatric Nursing Assistant (GNA) #27, who was assigned to the care of the resident on 5/9/24. GNA #27 reported to the surveyor that when they entered the resident's room on 5/9/24, Resident #3 was left laying on their side from after wound rounds and Resident #3 stated to them that they needed LPN #5 to do their dressing. GNA #27 further reported that on 5/9/24, Resident #3 stated the following to them in response to the incident: Wound rounds left me like this. At this time, GNA #27 confirmed with the surveyor that the resident was upset by the incident. GNA #27 confirmed they believed it had been several hours since the resident had been checked on last, and additionally reported, that after the incident, all parties involved were taken to the Director of Nursing's office where staff were asked if they understood the severity of the situation. Further review of the facility's complete investigation file revealed a written statement by Wound RN #28 regarding the 5/9/24 incident, which included the following: I entered first and noted location of (Resident #3's) call bell. I asked if s/he could tap it- s/he tried- unsuccessful. No documentation was found regarding any actions having been taken by Wound RN #28 in response to their initial finding that Resident #3 was unable to tap the call bell. On 6/11/24 at 1:26PM the surveyor conducted an interview with Licensed Practical Nurse (LPN) #20, who reported the following information regarding their role with wound rounding on 5/9/24: My job was to make sure the resident was prepped for the doctor to come in and see them. The doctor, wound nurse, and I went in and turned the resident on their side. When the surveyor inquired as to if the resident was left by the team with the call bell within reach, LPN #20 replied that they did not remember. Upon surveyor inquiry as to what measures were being put into place following the incident to prevent recurrence, they reported to the surveyor that temporary dressings were now being applied after at the conclusion of wound team rounding, so that no one has to be positioned in a way they can't reach a call bell. Further review of the facility's investigation revealed a statement collected from LPN #5, dated 5/10/24 which stated the following: Regarding repositioning, I am unable to confirm that it was performed as assigned GNA stated s/he knows residents routine. Wound nurse did not notify myself or orienting nurse that wound team saw resident during wound rounds to prioritize resident's wound treatment above all other tasks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's complete investigation file for the 5/9/24 incident revealed the Administrator's documented timeline review of camera footage of when staff was in the resident's room on 5/9/24: 9:33-9:38AM: Registered Nurse- Wound Nurse #28, LPN #20, and Physician #29, go into room (LPN #20 is last one to exit room) 1:18PM-GNA goes in room 1:21PM (LPN #5) goes in room as well 1:22PM RN #20 goes in to room as well, works on getting treatments from cart with LPN #5 1:27PM RN #20 and LPN #5 exit room 1:37PM GNA exits room. Review of the camera footage timeline documentation revealed no staff present in the resident's room between the hours of 9:38AM and 1:18PM, approximately three hours and forty minutes. Further review of the facility's complete investigation file revealed written information dated 5/9/24 by LPN Unit Manager #1, stating the following information: (Resident #3) did not request to not have the GNA or nurse again. S/he just wants to be taken care of and I agree totally. LPN Unit Manager #1 further documented they believed the assigned staff required education secondary to the resident's complaint. Continued review of the complete investigation file revealed the following information documented in employee education notes and/or disciplinary action form: On 5/9/24 resident was seen by wound rounds and was left on side with no dressing to sacrum. Resident is totally dependent on staff for repositioning and care. Resident is incapable of reaching for call bell and needs to be positioned in such a way that s/he is able to utilize the call bell for assistance. On 5/9/24 during wound rounds, a nurse was covering for a regular wound round staff member, and a dependent resident was left on his/her side, with call bell not able to be reached. In addition, the dressing was not intact, leaving wound exposed. On 5/9/24 [Resident #3] was left in a flat position after wound rounds and unable to have his/her call bell in reach. [Resident #3] is at high risk for pressure ulcers and aspiration and turning and repositioning are necessary for skin integrity and to prevent aspiration. Review of the active medical order dated as beginning on 12/28/22 on the treatment administration record for the month of May 2024 revealed the following was ordered to occur: Turn and reposition every 2 hours (every shift) every shift strict t & p (turning and repositioning) Q (every) 2 hrs. Review of the facility-reported incident alleged to occur on 5/11/24 and 5/12/24 revealed documentation that a weekend supervisor was called to the resident's room on 5/12/24 around 2pm, and it was reported that Resident #3 felt like food was coming up and was scared of aspiration and unable to call for help. The documentation submitted in the initial self report to the Office of Healthcare Quality on 5/13/24 documented a concern that the Resident was left in bed from 6pm to 6:30am without access to her call bell and being left in the same position. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor review of the facility's follow-up self-report dated 5/17/24 regarding this second incident revealed the following information was documented by the facility: DON/NHA (Nursing Home Administrator) apologized on behalf of the facility that the situation occurred. DON and NHA placed the touch call pad in different locations near his/her cheek and hand and the Resident was unable to press the call bell in any position, regardless of proximity. Discussed concern for the resident not being able to use the call bell. Facility documentation for the conclusion/outcome of their investigation revealed it was deemed inconclusive, however, the facility documented the following in their conclusion: It is confirmed that the GNA did not provide care from 11p-6:30am. The nurse provided medications around 10pm and early morning medications/flush around 6:30am. The nurse did see the resident sleeping around 3-4am with no distress noted. On 5/30/24 at 2:16PM the surveyor conducted an interview with the Administrator and DON, at this time they confirmed with the survey team that based on their camera footage review of both shifts for 5/11 and 5/12/24, no one was in the room from approximately 11pm to 6:30am, and further confirmed that the documentation in the investigation file of camera footage times was for the dates of 5/11/24 and into 5/12/24. Review of the facility's complete investigation file for the 5/11/24 and 5/12/24 incident revealed the Administrator's documented timeline review of camera footage of when staff was in the resident's room on 5/11/24 into 5/12/24: 6:47-6:58PM- LPN #31 in room 8:49-9:01PM- LPN #31 in room 9:09PM- RN #28 and RN #26 open door and check in on Resident 10:40pm-10:43PM GNA #32 goes into room 6:30-6:35AM LPN #31 in room 6:38-7:00am GNA in room On 6/3/24 at 3:26PM the surveyor conducted an interview with the Administrator and DON who both verbally confirmed to the survey team that no staff was in the resident's room during the timeframe overnight in question. The DON stated to surveyors that a nurse was seen rounding, but did not go into Resident #3's room. The DON further confirmed with the surveyor that the overnight tube feed for the Resident needed to be checked on, and could not be observed appropriately from the hallway. On 6/3/24 at 10:43AM the surveyor conducted an interview with the DON who stated the following was their documentation expectation for facility staff: There should be something in the medical record that staff met with the resident and concerns were addressed. On 6/6/24 at 9:10AM the surveyor conducted an interview with the Administrator who reported there was no current process in place to ensure that documentation of resident complaints ends up in their medical records. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at approximately 10:37AM the surveyor conducted an observation of Resident #3's room from the hallway prior to entering the room, and noted the resident's feed pump was unable to be visualized from the nursing unit hallway, and the resident was unable to be effectively visualized from the nursing unit hallway. After the facility concluded their final investigation on 5/17/24, and after surveyor intervention, the DON reported that disciplinary action would take place because of the rounding and checking on the infusing tube feeding that did not occur. Further surveyor review of the facility's complete investigation file revealed GNA #33 was assigned to the resident for the 11PM to 7AM shift beginning on 5/11/24 and into 5/12/24, as confirmed by the staffing schedule and their statement. The surveyor noted the following information included in GNA #33's statement sent to the DON: Upon commencing my shift, I found [Resident #33] asleep. I began my rounds at 5am, attending to him/her at approximately 6:30AM. During my care routine, I stopped his/her feeding before I attended to her personal needs, I completed my tasks by resuming her feeding and turning off the lights before departing his/her room. The surveyor noted at this time that the GNA was describing they had manipulated the Resident's tube feed pump. On 5/31/24 at 2:41PM the surveyor conducted an interview with the DON who reported the following information: The issue we had with them [GNA #33] was the 2 hour rounding not being done. When the surveyor further inquired as to the GNA performing stopping and starting of the tube feeding, the DON replied: The issue was the 2 hour rounding, I didn't catch that. The DON further reported that the issue of the tube feed not being checked on by LPN #31 was not thought of until recently, and they did not realize this issue at the time of their investigation. Further surveyor review of the investigation file revealed GNA #33 was not allowed to return to the facility beginning on 5/13/24, and the facility documented a complaint that was made regarding GNA #33 to the Maryland Board of Nursing. The following information was included in the investigation file: It was determined that the GNA (#33) was assigned 11PM-7AM but did not go into the Resident room for any care until 6:30AM. NHA notified GNA #33 that camera footage was reviewed and there was no evidence of him/her going into the room. On 6/11/24 at 12:20PM, after surveyor intervention, the Administrator informed the surveyor that a follow up complaint to the Maryland Board of Nursing, regarding GNA #33's documented actions of starting and stopping the Resident's tube feed pump were made on 6/11/24, and provided a copy. On 6/12/24 at approximately 9:03AM the surveyor shared concerns with the facility Administrator and DON, who both acknowledged understanding of the concerns. 48168 2) On 5/28/24 at 3:08 PM in an observation of Resident #71, a sign posted above the resident's bed indicated that the resident used a hand splint for their right hand. On 5/31/24 at 1:43 PM a review of Resident #71's physician orders revealed that there were no orders regarding the resident's hand splint. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/24 at 12:07 PM an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) was conducted to review splint care for Resident #71. The DON stated that the resident had used the splint since 2022. The DON was asked about the orders for the splint and documentation of the resident's use and response to use of the hand splint. The DON responded that she could not find any order for the splint or care of the splint, and because there was no order entered into the medical record the care was not entered into the Treatment Administration Record where documentation of care would be documented. She stated that there should have been an order and care documentation for the resident's splint care. She could not explain why the order and documentation was not in the resident's records.