STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215348	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Taneytown, Inc	100 Antrim Blvd Taneytown, MD 21787

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, it was determined that facility staff failed to provide treatment and care in accordance with professional standards of practice after a resident fall that resulted in serious injury, resulting in death. Resident #2 died from the injuries sustained from the fall. This was evident for 1 (#2) of 3 residents reviewed for falls with serious injury.As a result of these findings, a state of immediate jeopardy (IJ) was declared on [DATE] at 3:55 PM and an IJ summary tool was provided to the facility at that time. The facility submitted the first draft of their plan to remove the immediacy on [DATE] at 5:30 PM and it was not accepted. The facility submitted a second draft at 5:55 PM, and it was not accepted. The third draft was submitted at 6:09 PM and the facility ' s written plan to remove the immediacy was accepted on [DATE] at 6:20 PM with an alleged date of compliance of [DATE].The findings include:On [DATE] at 3:22 PM a medical record review for Resident #2 revealed the attending physician ' s history and physical note dated [DATE]. Resident #2 was hospitalized for infections and after treatment the resident was sent to the facility for rehabilitation services because s/he was weak. The resident was diagnosed with advanced dementia and anxiety especially at night.On [DATE] at 6:43 AM, a review of the video recording from the facility ' s surveillance camera located at the [NAME] wing nurses ' station was conducted. The video recorded that on [DATE] at 12:08 AM, Resident #2 was sitting in a reclined geriatric chair (referred to as a geri chair, it is a padded chair that reclines and is on wheels) in the nurses ' station unsupervised. The resident stood up and attempted to walk out of the nurses ' station without assistance. The resident was observed falling on their right side, making no attempts to catch themselves. The resident laid motionless on the floor then at 12:10 AM, Geriatric Nursing Assistant (GNA) #6 was observed back at the nurses ' station, without taking a moment to check the resident, she started waving her arms towards the central nurses ' station as if she was trying to get someone ' s attention. Then she walked down to the central nurses ' station. GNA #6 then returned to the resident, who was still lying on the floor and started pulling on the resident ' s left arm as if to roll the resident over before a nurse was able to assess the resident. It was observed the resident had a pool of blood on the floor next to his/her head. The GNAs were placing pads under the resident ' s head. Registered Nurse (RN) #7 and RN #8 were observed walking down the hallway from the central nurses ' station. There was no sound available, but RN #7 was observed leaning over the resident ' s face and head. The nurse was not observed conducting a thorough assessment such as checking for signs of an injury to ensure it was safe to move the resident and conducting a neurological exam (referred to as a neuro check, blood pressure, pulse, respirations, temperature, and level of oxygen in the blood, hand grips, foot pushes, pupil size and reaction.). Neuro checks should have been obtained at the time of the fall and every 15 minutes for the first hour or until Emergency Medical Services (EMS) personnel arrived. She indicated to the GNAs and RN #8 to help her get the resident back into the chair. Once the resident was back in the chair, RN #7 leaned over the resident for a few minutes and moved the resident ' s hands. When the resident was placed back in the chair, resident #2 was observed to have a round knot on the right temple and his/her nose was bloody. Without conducting a thorough assessment, a neuro check, and/or rendering first aid to the resident, At 12:15 AM RN #7 and RN #8 left the resident with the GNAs and walked back towards the central nurses ' station. It was observed on the video that the knot on the resident ' s temple grew into an oval shape, however the nurses left so they were unaware that this was happening. RN #8 came back at 12:25 AM and wrote down a few things then left at 12:27 AM. She failed to assess the resident for changes or conduct a neuro check. EMS arrived at 12:46 AM, 35 minutes after staff were aware the resident had fallen. RN #7 came back at 12:51 AM, after EMS arrived.A review of the EMS Comprehensive Report on [DATE] at 3:45 PM, revealed 911 was called on [DATE] at 12:41 AM, 31 minutes after the resident fell. EMS was dispatched at 12:43 AM. Per the report the residents ' blood oxygen level decreased and the resident needed supplemental oxygen. EMS staff were unable to get the oxygen back to a normal level before arriving at the nearest hospital. The resident was deemed a level 3 priority resident. On [DATE] at 8:24 AM the emergency room report read that Resident #2 had a computerized tomography (CT) scan of the head which showed s/he suffered from hemorrhaging on the left side of the brain to include bleeding at the site of the hematoma on the resident ' s head that could be viewed in the video. The injury warranted surgical intervention; however, the family chose not to put the resident through the surgical procedure. The resident was given medications to reverse the bleeding, however, subsequently died [DATE] at 9:16 AM. The

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, record review and interview, it was determined that facility staff failed to ensure that residents had adequate supervision to prevent falls with serious injury. As a result of this deficient practice Resident #2 died due to the injuries sustained from a fall. This was evident for 1 (#2) of 3 residents reviewed for falls. As a result of these findings, a state of immediate jeopardy (IJ) was declared on 6/20/25 at 4:55 PM and an IJ summary tool was provided to the facility at that time. The facility submitted the first draft of their plan to remove the immediacy on 6/20/25 at 6:40 PM and it was not accepted. The facility submitted a second draft at 7:52 PM, and it was not accepted. The third draft was submitted at 8:02 PM and the facility ' s written plan to remove the immediacy was accepted on 6/20/25 at 8:30 PM with an alleged date of compliance of 6/23/25.The findings include:A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 6/18/25 at 3:22 PM a medical record review for Resident #2 revealed the attending physician ' s history and physical note dated 4/8/25. Resident #2 was hospitalized for infections and after treatment the resident was sent to the facility for rehabilitation services because s/he was weak. The resident was diagnosed with advanced dementia and anxiety especially at night. Review of the progress notes revealed the resident frequently tried to get out of bed without assistance. A review of the baseline care plan revealed that staff noted the resident had a risk for falls, however, failed to implement resident-centered interventions to address the level of supervision the resident required to prevent accidents. Facility staff checked that the resident needed floor mats.On 6/20/25 at 6:43 AM a review of the video recording from the facility ' s surveillance camera at the [NAME] wing nurses ' station was conducted. The video was time stamped for 4/19/25 at 11:36 PM, and showed Resident #2 was brought to the nurses ' station by GNA #5 and GNA #6. The resident was in a reclined geri-chair, covered with a blanket and sheet. At 11:45 PM GNA #5 left the nurses station and then at 11:56 PM GNA #6 left the nurses ' station and Resident #2 was left unsupervised. At 12:06 AM on 4/20/25, Resident #2 was observed throwing the covers back and attempting to stand up. The resident attempted to push the reclined footrest down, but could not. The gerichair started moving back as the resident continued to try to stand. Then GNA #5 returned to the nurses ' station and attempted to get the resident to scoot back in the chair but was unsuccessful. When GNA #6 returned a few seconds later, they both repositioned the resident in the reclined gerichair. The GNAs failed to offer the resident to walk, go to the bathroom, food or a drink to determine the possible reason the resident was trying to get up. GNA #6 wrapped the resident ' s feet with the blankets as they both left the nurses ' station at 12:08 AM. After attempting to get out of the reclined geri chair without assistance the GNAs left the resident unsupervised a second time. After the GNAs left, The resident got out of the chair, threw the covers up, and after unwrapping his feet from the blanket, stood up. The resident used furniture in the nurses ' station to hold on to, made their way to the counter height portion of the desk and fell. The resident fell on the right side and made no attempts to catch themselves. The resident laid motionless on the floor and at 12:10 AM, GNA #6 was observed back at the nurses ' station, and she started waving her arms. Then without checking to see if the resident was ok, she walked down to the central nurses ' station. GNA #6 returned to the resident, who was still lying on the floor and started pulling on the resident ' s left arm as if to roll the resident over before a nurse was able to assess the resident. It was observed the resident had a pool of blood on the floor next to his/her head. The GNAs were placing pads under the resident ' s head.RN #7 and RN #8 were observed walking down the hallway from the central nurses ' station area. Upon arrival, there was no sound available, but RN #7 was observed to lean over the resident near his/her head and shoulders for a few seconds. The nurse was not observed conducting a thorough assessment such as checking for signs of an injury to ensure it was safe to move the resident and conducting a neurological exam (referred to as a neuro check, blood pressure, pulse, respirations, temperature, and level of oxygen in the blood, hand grips, foot pushes, pupil size and reaction.). Staff were observed picking up the resident and sitting the resident back in the reclined geri chair. Once back in the geri chair a large knot was observed on resident #2 ' s right temple and the resident ' s nose was bleeding. RN #7 leaned over the resident for a few seconds and left the nurses ' station without rendering first aid. Further review of the video revealed that RN #7 did not go back to the nurses ' station to check on the resident, until EMS arrived 35 minutes later. The GNAs wiped the resident ' s nose and the resident wiped his/her nose. However, at no time did staff apply pressure to the top of the nose to stop the bleeding. The GNAs changed the blankets because they were soiled with blood. EMS arrived at 12:50 AM and took

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview it was determined that the facility failed to ensure that they had competent staff on duty to provide care to their residents. This was evident for 1 (#2) of 3 residents reviewed for falls with serious injuries.The findings include:On [DATE] at 6:43 AM a review of the video recording from the facility's surveillance camera at the [NAME] wing nurses' station was conducted. The video was time stamped for [DATE] at 11:36 PM. Resident #2 was observed being pushed in a reclined Geri chair to the nurses' station by GNA #5 (agency staff) and GNA #6 (agency staff). At 11:56 PM GNA #6 left the resident unsupervised in the nurses' station. Then at 12:06 AM on [DATE], Resident #2 was attempting to get out of the chair unassisted and GNA #5 and #6 came back and repositioned the resident in the chair. Both GNAs left the nurses' station and Resident #2 was unsupervised in the reclined Geri chair after the resident was trying to get out of the chair unassisted. Immediately after the GNAs left the nurses' station, the resident was able to get out of the chair and attempted to walk out of the nurses' station unassisted. The resident fell, hitting his/her head. The resident later died at the hospital due to the injuries from the fall. A review of GNA #6's (the GNA who was assigned to care for Resident #2) employee file on [DATE] at 1:38 PM revealed was employed by an agency. The file provided had no evidence that the GNA's level of competence was evaluated to ensure she could safely provide care to the residents. An interview with the Human Resources Director (HRD) on [DATE] at 2:44 PM revealed that when an agency staff member started at the facility they were required to shadow another GNA for their first shift. However, there was new hire checklist to documentno record keeping that this occurred and what was reviewed with them. Secondly, the facility provided no training or evaluations for the agency staff. Agency staff receive a packet of information from the front desk on their first day. On [DATE] at 8:53 AM an interview with the Staff Developer (SD) revealed she had no training or competency program for the agency staff. A telephone interview with the Director of Nursing (DON) on [DATE] at 8:41 AM revealed she watched the video and was concerned that GNA #6 had left the resident unsupervised. During a subsequent interview on [DATE] at 9:46 AM with the DON she confirmed they had no process for training and evaluating the agency staff. She reported that their competencies were completed through the agency, however, there was no evidence of this being done. 2) A continued review of the video on [DATE] at 6:43 AM revealed Resident #2 lying on the floor after the fall and GNA #6 finds the resident and goes up to central nurses' station and comes back. Then RN #7 and RN #8 (who was being precepted by RN #7) were observed walking down the hallway from the central nurses' station area. RN #7 failed to appropriately assess the resident for injuries prior to moving the resident off the floor. RN #7 failed to conduct neurological assessment (referred to as a neuro check, blood pressure, pulse, respirations, temperature, and level of oxygen in the blood, hand grips, foot pushes, pupil size and reaction.). The resident was observed to have a large knot on his/her right temple and a nosebleed. RN #7 left the resident before rendering first aid. Because she left so quickly after the fall she was not aware that the knot on the resident's head was growing rapidly which can be a sign of active bleeding. She failed to check on the resident until emergency medical services) EMS arrived 36 minutes later. A review of the EMS Comprehensive Report on [DATE] at 3:45 PM, revealed 911 was not called until [DATE] at 12:41 AM, 31 minutes after the resident fell.A telephone interview with the Director of Nursing on [DATE] at 8:41 AM revealed she had concerns with RN #7's lack of immediacy during the incident and that she had not fully assessed the resident. Cross Reference: F684 and F689

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and interview, it was determined that the facility failed to develop all the required training requirements and have a process in place to ensure that all staff received the required trainings. This was evident for 3 (#7, #9, and #15) of 4 facility staff reviewed training requirements and 2 (#5, #6) of 3 contracted staff reviewed for training requirements. The findings include:1) A review of Staff #7's employee file on 6/23/25 at 1:55 PM revealed she was hired in 2019. She had not received training on the facility specific Compliance and Ethics training, Quality Assurance Performance (QAPI) and Improvement training, and Infection Control and Prevention (ICP) training. 2) A review of Staff #9's employee file on 6/23/25 at 1:28 PM revealed she was employed by the facility in 2024. She had not received training on the facility specific Compliance and Ethics training, Quality Assurance Performance (QAPI) and Improvement training, and Infection Control and Prevention (ICP) training.3) A review of Staff #15's employee file on 6/23/25 at 1:20 PM revealed she had been employed by the facility since 2021. She had not received training on the facility specific Compliance and Ethics training, Quality Assurance Performance (QAPI) and Improvement training, and Infection Control and Prevention (ICP) training. 4) A review of Staff #5's employee file on 6/23/25 at 1:48 PM revealed she was contracted through a staffing agency and started working at the facility in 10/2023. The facility failed to ensure that she had communication and behavioral Health training. In addition, they failed to ensure that she received training based on the facility's program policies and procedures for compliance and ethics training, QAPI, and ICP. 5) The employee file for Staff #6 was reviewed on 6/23/25 at 1:28 PM and this review revealed she was employed by a staffing agency and started working at the facility in 3/2025. The facility failed to ensure that she had communication training. She had not received the facility specific program policies and procedures training for compliance and ethics, QAPI, and ICP. An interview with the Director of Human Resources (DHR) on 6/24/25 at 2:44 PM revealed the facility had an online training that was sent from the corporate office for the facility staff to complete on hire and annually thereafter. She reported there was no orientation or onboard training requirements for the contracted staff except for some contracted staff were required to shadow another staff member for their first 8-hour shift. Reviewed the finding on 6/25/25 at 12:50 PM with the Nursing Home Administrator. She reported that they had provided the QAPI and ICP training to the facility staff and offered to bring a printout for that training. She was unaware if the training was facility specific as it was sent from the corporate level. On 6/26/25 at 11:36 AM the printout for the QAPI and ICP trainings were reviewed and revealed that they were generic and not facility specific as required. Cross Reference F941, F944, F945, F946, and F949

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on record review and interview, it was determined that the facility failed to ensure that all staff who worked directly with residents had communication training. This was evident for 1 (#5) out of 3 contracted staff. The findings include:A review of Staff #5's employee file on 6/23/25 at 1:48 PM revealed she was contracted through a staffing agency and started working at the facility in 10/2023. The facility failed to ensure that she had communication training as required.An interview with the Director of Human Resources (DHR) on 6/24/25 at 2:44 PM revealed the facility had no online training requirements for the contracted staff. She reported that the agency that employed them provided the required trainings. She reported that she does not review their training program when they start working at the facility. The findings were reviewed with the Director of Nursing and Nursing Home Administrator on 6/26/25 at 1:43 PM.Cross Reference F940

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on record review and interview, it was determined that the facility failed to develop a mandatory training course that included the facility's standards, policies, and procedures regarding their Infection Prevention and Control (IPC) program. This was evident during the review of the facility's training program and has the potential to affect all residents. The findings include: On 6/26/25 at 11:36 AM the printout for the Infection Control training course that was required for facility staff to review on hire and annually thereafter was conducted. The training was an overview of infection control and failed to include the standards, policies and procedures of the facility IPC program. An interview with the Director of Human Resources (DHR) on 6/24/25 at 2:44 PM revealed the facility had an online training program that was sent from the corporate office for the facility staff to complete on hire and annually thereafter. She reported there were no online training requirements for the contracted staff. The findings were reviewed with the Director of Nursing and Nursing Home Administrator on 6/26/25 at 1:43 PM. They were unaware that the required IPC training was supposed to be facility specific. Cross Reference F940

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on record review and interview, it was determined that the facility failed to have a process in place to ensure that all staff received facility specific compliance and ethics training. This was evident for 2 (#5, #6) of 3 contracted staff reviewed for training requirements. The findings include:1) A review of Staff #5's employee file on 6/23/25 at 1:48 PM revealed she was contracted through a staffing agency and started working at the facility in 10/2023. The facility failed to ensure that she received the mandatory, facility specific compliance and ethics training. 2) The employee file for Staff #6 was reviewed on 6/23/25 at 1:28 PM and this review revealed she was employed by a staffing agency and started working at the facility in 3/2025. The facility failed to ensure that she received the mandatory, facility specific compliance and ethics training.An interview with the Director of Human Resources (DHR) on 6/24/25 at 2:44 PM revealed the facility had no online training requirements for the contracted staff. She reported that she does not review their training list prior to their first day at the facility. Reviewed the finding on 6/25/25 at 12:50 PM with the Nursing Home Administrator. She acknowledged the concern. Cross Reference F940