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	09/25/2025

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interviews, and record reviews, it was determined that the facility failed to post the required daily nurse staffing information in a clear and accessible location. This was evident for 31 out of 31 days of staffing records reviewed.The findings include:On 9/22/2025 at 8:40 AM, the Surveyor observed a whiteboard near the central nursing station and asked the Licensed Practical Nurse (LPN)/Unit Manager (Nurse #8) who was responsible for writing the information on the board each day. Nurse #8 stated that the charge nurse was responsible. The Surveyor observed the board and noted the following:The facility name was not included.The manager on duty section was left blank.Two nurses were listed, but their full names and titles (Registered Nurse [RN] or LPN) were not indicated.The Certified Medicine Aide (CMA) and Geriatric Nursing Assistants (GNAs) were listed by first name only.The board included 7-3 but did not specify hours scheduled versus hours worked.Staffing ratios were listed as 9:53, Licensed, 2:53, and Unlicensed 7:53 without clarification of what constituted licensed versus unlicensed staff.When asked if the information was available elsewhere, Nurse #8 stated it was only posted on the whiteboard. She reported that the information was provided to her by the facility Staffing Coordinator (Staff #14). The Surveyor then asked to review the staffing binder. Upon review, there were no previous dates maintained in the binder. When asked where to locate prior postings, Nurse #8 stated that the Staffing Coordinator would have that information.The Surveyor then walked to the second nursing station and observed that no nurse staffing information was posted at that location.On 9/22/25 at approximately 8:45 AM, the Surveyor requested the past month of nursing assignment sheets from Staff #14. They were provided around 10:00 AM. Review revealed that none of the postings from 8/22/25 to 9/21/25 included the facility name, daily census, manager on duty, or total hours scheduled versus worked. Multiple postings also lacked full names and titles of staff (dates: 8/22, 8/25-8/31, 9/1-9/6, 9/8-9/12, 9/14-9/21).On 9/22/2025 at 10:33 AM, the Surveyor conducted an interview with the Staffing Coordinator (Staff #14) and asked her to explain her understanding of the facility requirement for posting nursing staffing information. She stated that she needs to include nurses, aides, and who is on call, and include that the charge nurse on duty will make the room assignments. She stated they also include the date.The Surveyor asked if they typically include the census, and she stated, we don't usually put the census on the daily schedule. The Surveyor asked if they included the hours scheduled versus the hours worked, and she stated, No, that is not included. The Surveyor asked where they post the nursing assignments in the facility, and she stated that they include it in our OnShift (internal computer system). The Surveyor asked if the nursing schedule and assignments are posted for the public, and she stated that they are not. The Surveyor asked if she was aware of the regulatory guidelines for posting the nursing schedule, and she stated, I am not aware.The Surveyor reviewed the concerns over the missing data and asked Staff #14 to look over them. She agreed with the Surveyor's findings and stated that I used to include all the information on the schedule but the staff had complained that it was too much information to include and so I made the change. She said that she didn't realize the regulation was probably the reason the old documentation included all the information and stated that she would go back to posting the schedules daily with the required information.On 9/22/25 at 11:00 AM, the Surveyor spoke with the Director of Nursing (DON), who acknowledged that neither the (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
	215348	A. Building B. Wing	09/25/2025

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	whiteboard nor paper schedules included all required information and confirmed that staffing assignments are not posted at any nursing station or elsewhere in the facility.

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	09/25/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. During the initial tour of the facility on 09/22/2025, at 9:06 AM, Residents #67 and #17 reported that the facility's food was bland and cold for foods that needed to be warm. An observation of the facility's lunch tray line service was conducted on 9/22/2025 at 12:30 PM. The surveyor requested a test tray at that time. The tray contained Roast beef, steamed vegetables, one dinner roll, margarine, pumpkin pie, vanilla ice cream, cranberry juice, roasted red potatoes, salt, and pepper.Staff #12, the Dietary Director, who was present, took the temperatures of the food items, which showed 137 degrees for the steamed vegetables, 121 degrees for the roasted potatoes, 146 degrees for the Roast beef, 63 degrees for the pumpkin pie, and 61 degrees for the cranberry juice. Staff #12 indicated that the acceptable temperatures should have been 140-165 degrees F for the steamed vegetables, 140-165 degrees F for the roasted potatoes, 40 degrees F or less for the pumpkin pie, and cranberry juice. A review later that day of the facility's policy and procedure on food preparation and service contained a statement that while food is being stored, prepared, served or transported to the residents, it is protected from contamination. It is necessary to keep foods refrigerated below 45 degrees F and heated to temperatures above 140 degrees F to prevent the growth of any pathogenic organisms. However, earlier observations of a test tray, taken directly from the food service line, showed temperatures lower than 140 degrees for foods that required warming and over 45 degrees for foods that needed to be kept cold.In an interview on 9/23/2025, at 4:51 PM, staff #12 reported that she would provide training to her staff on the proper temperatures of the food served to residents.

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	09/25/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, it was determined that the facility failed to store food in accordance with professional standards. This deficient practice has the potential to affect all residents. The findings include:1) An observation of the facility's Refrigerator #10 with Staff #12, the Dietary Director present, on 9/22/2025 at 8:10 AM showed the following:-Leftover onion ring sauce with a date prepared as 9/19/25 and had no use-by date.-Ranch dressing with a date prepared of 9/20/25 and no use-by date.-Leftover orange sesame dressing with a date prepared as 9/21/25 and no use-by date.-Leftover crab syrup with a date prepared as 9/19/25 and no use-by date-An open carton of liquid whole egg with no open date-A container of raw frozen burgers was placed on the top shelf above salad dressings/sauces to thaw. Staff #12 said the burgers were placed in the refrigerator to thaw; however, they should have been placed on the lower shelf. Staff #12 then moved the fresh burgers to the lower shelf.2) An observation of the facility's Walk-in freezer #3 on 9/22/2025 at 8:15 AM showed the following:-An open bag of frozen toasted bread, which had no open or use-by date. Staff #12 said that it should have been put in a Ziplock bag and dated.-Open bags of waffles, pancakes, and chicken tenders were noted with no open or use-by date. Staff stated they should have been ziplocked and dated as well.The continued observation of the freezer temperature was noted to be 10 degrees. Staff said it should be less than 0 degrees.A review of the temperature logs for freezer #3 from July to September 2025 was completed. The form for recording the log indicated that the freezer temperature should be less than zero. However, in July, the recorded temperatures for 28 out of 31 days were above zero degrees, reaching a high of 36. In August, the temperatures recorded for 30 consecutive days ranged from 6 to 28 degrees. In September, the recorded temperatures for 21 days ranged from 3 to 15 degrees. 3) An observation of the facility's walk-in freezer #1on 9/22/2025, at 8:20 AM, showed a bag of meatballs with an open date of 1/16/25 and had no use-by date. Staff #12 stated that it should have been labelled with a use-by date as well. 4) An observation of the facility's Refrigerator #6 on 9/22/2025 at 8:25 AM showed that it contained juices, milk, and sandwiches for Residents. Continued observation of Refrigerator #6's temperature showed a reading of 50 degrees. Staff #12 confirmed that the temperature was 50 degrees and then stated that the refrigerator's temperature should be 40 degrees or lower. A review of the facility's policy on Food Storage stated that every refrigerator must be equipped with an inside thermometer and will not exceed 40 F. Freezer Temperature 0 to -10 F. However, earlier observations and a review of the temperature logs for freezer #3, from July to September 21, 2025, revealed temperatures greater than zero, reaching up to 36 degrees, and the facility failed to respond to these temperatures.In an interview on 9/22/2025, at 2:48 PM, staff #12 stated that she would notify the facility's maintenance department to check the freezer after the surveyor's intervention.During a subsequent interview on 9/23/2025, at 8:11 AM, staff #12 reported that Refrigerator #6 had been completely emptied, and a refrigerator company had been contacted to repair it after the surveyor's intervention. Staff #12 also indicated that Freezer #3 had been repaired following the surveyor's intervention.On 9/25/2025 at 1:26 PM, the chief clinical officer (COO) was made aware of the concerns of not labeling foods, and warmer freezer and refrigerator temperatures. The COO reported that he had already been made aware of all the concerns in the facility's kitchen and had provided training to Staff #12, who would also train all her staff regarding the concerns.

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	09/25/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure the dishwasher was maintained in a safe operating condition, as evidenced by low temperature logs. This deficient practice has the potential to affect all residents who receive meals from the facility's kitchen. The findings include:During a tour of the kitchen on 9/22/2025 at 8:02 AM, staff #12, the Dietary Director, reported to the surveyor that the dishwasher had just broken, so staff had to wash the dishes manually. Later that day, a review of the dishwasher temperature logs from June to August 2025 was done. The form for recording the logs contained the acceptable minimum temperatures for the dishwashing process: wash 140-160 degrees, Rinse 180 degrees or higher. The review also showed that, for the month of June, the recorded final rinse temperatures after breakfast and Lunch were within the range of 100 to 130 degrees for 23 out of 30 days, which were below the minimum final rinse temperatures; and 7 days had no recorded temperatures. July's recorded final rinse temperature logs for 30 out of 31 days were between 130 and 150 degrees, which were below the minimum final rinse temperature of 180 degrees. August's recorded final rinse temperatures after breakfast and Lunch for 28 out of 31 days were within the range of 120 to 135 degrees and below the minimum final rinse temperature of 180.Further review of the manufacturer's information about the dishwasher presented to the surveyor by staff #12 noted that the dishwasher was a high temp dishwasher, which sanitizes dishes using hot water, rather than chemicals. The machine sanitizes at a temperature of 180 F or higher during the final rinse cycle. In an interview, staff #12 confirmed that the final rinse temperature logs recorded after breakfast and Lunch from June to August 2025 were outside the acceptable final rinse minimum of 180 F or higher. Staff #12 added that she was not aware that the temperatures had been out of range for the dishwasher's final rinse. During a subsequent interview on 9/23/2025, at 1:36 PM, staff #12 stated that she did not typically check the temperature logs of the dishwasher, so she was not aware that the temperatures were lower than the acceptable minimum temperature at the final rinse necessary for sanitizing the residents' dishes, flatware, and utensils from June to August. Staff #12 added that she only shut down the dishwasher in the first or second week of September 2025.Staff #12 also indicated that the water heater booster was not working correctly, which was the reason why the final rinse temperature logs were outside the acceptable temperature range. However, the facility did not act upon the low temperature recordings from June to August. In an interview on 9/23/2025 at 4:51 PM, staff #12 stated that she was providing training to her staff on the dishwashing process and what to do when the temperatures were not reading correctly. Staff also indicated that the facility was waiting for a dishwasher company to repair it.

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	09/25/2025

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 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 a review of medical records and interviews, it was determined that facility staff failed to immediately report an allegation of resident abuse. This was evident for 1 (Resident #69) of 4 residents reviewed for abuse during a survey. Findings include:On 9/23/25 at 3:10 PM, a family member reported concerns about the care Resident #69 was receiving. These concerns included an allegation that a nurse threatened to withhold medication from the resident.On 9/24/25 at 4:02 PM, Resident #69, a resident admitted for rehabilitation and without cognitive decline was interviewed. During the interview, Resident #69 stated that on the first day at the facility, a call bell was activated to request eye drops. Resident #69 reported the nurse responded, You aren't getting nothing tonight. Resident #69 confirmed receiving other medications but not eye drops.Additionally, Resident #69 recalled a separate incident in which a nurse was asked to identify the medications in a medication cup. The nurse reportedly replied, I don't know if they are just your medications, and added, If you don't want them, throw them out.On 9/23/25 at 4:19 PM, Nursing Supervisor (Staff #4) was interviewed. Staff #4 stated awareness that the agency nurse (Staff #5) did not administer the prescribed eye drops on the evening of 9/19/25. According to Staff #4, Resident #69 contacted a family member that evening after not receiving the eye drops. The family member called the facility around 10:22 and asked to speak with the nurse supervisor. The Nurse Supervisor Staff #4 then subsequently administered the eye drop medication at 10:30 PM.During the interview, Staff #4 reported asking Staff #5 why the eye drops were not given. Staff #5 allegedly responded, Resident #69 is in a COVID room, and I only go in when I have to. Staff #4 confirmed that the medication was ordered and available in Resident #69's room. Staff #4 also acknowledged a concerning conversation between the agency nurse and Resident #69. Staff #4 reported that she removed Staff #5 form providing care to Resident #69 for the remainder of the shift. Staff #4 advised the oncoming nurse supervisor not to assign Staff #5 to Resident #69 if Staff #5 was scheduled that weekend.Staff #4 acknowledged that threatening to withholding medication due to the resident's COVID status constituted neglect. However, the incident was not reported to the Director of Nursing (DON) or any other facility management at that time.On 9/23/25 at 4:47 PM, the DON and the facility's Chief Compliance Officer were informed of the concerns expressed by Resident #69 and the family.On 9/23/25 at 4:48 PM, the DON and Chief Compliance Officer were interviewed. The DON stated that allegations of abuse or neglect must be reported immediately to the DON or administrator and submitted to the Office of Healthcare Quality (OHCQ) within 2 hours.On 9/25/25 at 10:00 PM, a review of facility-reported incidents revealed that the above allegation was not reported until 9/23/25 at 6:30 PM.

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	09/25/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record reviews and interviews, it was determined that the facility failed to thoroughly investigate allegations of abuse. This was evident for 2 (Residents #17 and #55) of 4 residents reviewed for abuse allegations. In addition, the facility failed to protect a resident during the course of an investigation, which was evident for 1 (Resident #17) of 1 resident reviewed for abuse allegations.The findings include:Resident #17 has a medical history of a stroke, resulting in hemiplegia, a condition that causes paralysis or weakness on one side of the body. The resident has a Brief Interview for Mental Status (BIMS) score of 15, indicating no or very little cognitive impairment, suggesting intact thinking and memory. On 9/23/25 at 2:30 PM, the Surveyor reviewed records related to a facility-reported event (FRI) indicating that Resident #17 reported to the facility on 6/26/25 at 1:30 PM that two Geriatric Nursing Assistants (GNAs) had been rough with them when providing incontinence care. The aides reportedly stated that s/he was the equivalent of two people, referencing their weight. The resident further reported that the head of nursing got in on the deal, stating, Have you tried to lift your weight recently? They described feeling like a piece of meat and said, How dare they stand on two legs with two arms and treat me that way. S/he expressed that they did not want to be in that condition and worried about whether they would walk again. The facility obtained statements from Resident #17 and the two GNAs alleged to have been rough, but the investigation did not show evidence that other staff members or residents (aside from the roommate, who stated they were not aware of the incident) were interviewed. The facility suspended the two GNAs during the investigation, but there was no clarification regarding who the head of nursing was or whether that person was suspended. The facility ultimately found the claim unsubstantiated without conducting a full investigation. On 9/23/25 at 3:14 PM, the Surveyor interviewed the Director of Nursing (DON), who confirmed familiarity with the complaint and identified the head nurse as the Unit Manager (Nurse #8). When asked why Nurse #8 was not suspended along with the other alleged perpetrators, the DON stated it was because in an email she indicated she was joking. The DON acknowledged in retrospect that all three staff members should have been suspended during the investigation. When asked whether there was evidence that other residents or staff were interviewed, the DON stated she did not see any in the file. The Chief Clinical Officer (CCO), who joined the conversation, offered to provide the facility with an investigation template, emphasizing that abuse allegations should include interviews with other residents and staff to determine if others witnessed the event or had similar concerns. The DON indicated she would further investigate to determine if additional interviews were conducted. On 9/24/25 at 8:38 AM, the DON informed the Surveyor that no additional residents or staff were interviewed as part of the investigation and provided the email from Nurse #8 claiming she was joking with the resident about their weight. On 9/24/25 at 9:31 AM, the Surveyor spoke with the DON and CCO and reviewed the investigation findings, including Nurse #8's email confirming the joke about the resident's weight, the lack of suspension for Nurse #8, and the absence of interviews with other staff or residents. After this review, the DON acknowledged that the allegation had not been thoroughly investigated in accordance with regulatory guidelines 2) On 9/24/25 review of facility reported incident 335697 revealed that on 3/29/23 Resident #55 (continued on next page)

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	09/25/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported having received rough care that morning from GNA #6. Review of the facility's investigation documentation revealed documentation of an interview with Resident #55 and a handwritten statement completed and signed by GNA #6 on 3/29/25. No documentation was found to indicate other interviews were conducted in regard to this allegation. On 9/24/25 at 3:58 PM interview with the Director of Nursing (DON) revealed that the Nursing Home Administrator (NHA) usually conducts the abuse investigations but when the NHA is not here then it goes to her (the DON). When asked to describe what is involved in an investigation, the DON included getting statements from the resident, other residents and staff working at the time and potentially family. The DON confirmed that she would interview more than just the resident and the accused. Surveyor then discussed the concern that, based on review of the documentation provided, the only interviews conducted in relation to Resident #55's allegation, was Resident #55 and the accused GNA. As of time of survey exit on 9/25/25 at 2:15 PM no additional documentation was provided in regard to this concern.

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	09/25/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately recorded. This was evident for 2 (#30 and #70) of 3 residents reviewed for Skilled Nursing Facility Beneficiary Protection Notification.The findings include:The Minimum Data Set (MDS) is a complete assessment of the Resident that provides the facility with the necessary information to develop a plan of care, deliver appropriate care and services to the Resident, and modify the care plan based on the Resident's status. MDS assessments must be accurate to ensure that each Resident receives the care they need.1) Record review on 9/23/2025 at 1:54 PM of the Beneficiary Notification checklist completed and provided by the facility to the survey team showed that Resident #30's Medicare A services in the facility started on 7/31/25 and ended on 9/18/25. However, Resident #30's Discharge MDS, dated [DATE], recorded that Resident #30's Medicare A services ended on 9/19/25.In an interview on 9/23/2025 at 3:49 PM, staff #10, the MDS Coordinator, confirmed that Resident #30's Medicare End date was recorded inaccurately on his/her Discharge MDS dated [DATE].2) A review of Resident #70's medical record contained an MDS assessment dated [DATE] that documented that the Resident's Medicare A services started on 2/14/25 and ended on 4/1/25.However, a continued review of Resident #70's Notice of Medicare Non-Coverage (NOMNC) indicated that Resident's Medicare A services ended on 3/31/25.During an interview on 9/23/2025, at 3:55 PM, staff #10 stated that Resident #70's Medicare End date was 3/31/25 and that his/her MDS assessment, dated 4/1/25, was recorded in error. Staff #10 added that she would correct the MDS assessment to reflect the accurate date.

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	09/25/2025

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 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 record reviews and interviews, it was determined that the facility failed to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment. This was evident for 1 (Resident #26) of 2 residents reviewed for care planning.The findings include:Resident #26 was admitted into the facility in mid-2025.Minimum Data Set- The MDS is a federally-mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions.On 9/24/25 at 11:32 AM, Resident #26's medical record was reviewed and revealed the most recent MDS assessment was conducted for a significant (sig) change with an assessment reference date of 7/22/25. However, there was no documentation to indicate that a care plan meeting took place after the completion of this assessment.The Social Services Director (Staff #9) was interviewed on 9/24/25 at 11:37 AM. During the interview, she reported her role and that she attends the care plan meetings. She indicated that she always documents in the residents' progress notes on what was discussed during the meetings, and a sign-in sheet is provided to the attendees and kept in the resident's hard chart. She also reported that all care plan meetings are scheduled by the MDS coordinator (Staff #10).A subsequent review of Resident #26's medical record was conducted on 9/24/25 at 11:48 AM. The review revealed a progress note by Staff #9 that indicated a care plan meeting took place on 6/17/25 for his/her admission. The review also revealed the sign-in sheet in the resident's hard chart dated 6/17/25. There were no documents to indicate that another care plan meeting was held after 6/17/25.In an interview with the Staff #10 on 9/24/25 at 2:36 PM, she confirmed that she was responsible for scheduling care plan meetings. A review of Resident #26's medical record was conducted with Staff #10, and she reported that the sig change assessment was done due to the resident going in hospice care.Staff #10 also reported that a care plan meeting was required after completing a sig change assessment and when asked if she scheduled one after Resident #26's sig change assessment, she indicated no and stated, I thought for sure we did a care plan meeting for him/her because s/he switched to hospice, but it looks like it was missed.The concern that an interdisciplinary care plan meeting was not conducted after the completion of a comprehensive assessment was discussed with the Director of Nursing (DON) on 9/25/25 at 12:05 PM. the DON verbalized understanding and acknowledged the concern.

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	09/25/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews and interviews, it was determined that the facility failed to maintain resident records that were complete and accurate. This was evident for 1) one (Resident #4) of five residents review for unnecessary medications, and 2) one (Resident #69) out of five residents reviewed for abuse.The findings include:1). Resident #4 was admitted into the facility in late 2023 with diagnosis that include hypertension. Hypertension, or high blood pressure, is a condition where the force of blood against your blood vessel walls is consistently too high. This constant high pressure makes your heart work harder and can lead to serious health problems like heart attack, stroke, and kidney disease. Doctors measure your blood pressure (BP) as two numbers, written as a fraction, such as 120/80. Systolic (top number) and diastolic (bottom number) On 9/24/25 at 12:13 PM, Resident #4's medication orders were reviewed. The review revealed an order for Hydralazine for hypertension with instructions to hold if the Systolic Blood Pressure (SBP) was below 100. Resident #4's electronic Medication Administration Record (eMAR) was reviewed on 9/24/25 at 12:25 PM. The area to document the administration of hydralazine had areas indicated for the nurse initials and blood pressure readings. The Licensed practical Nurse (LPN #7) documented on 9/5/25 and 9/6/25 that she held the medication. However, there was no documentation for the BP reading. An interview with the nurse unit manager (LPN #8) was conducted on 9/25/25 at 9:40 AM. During the interview, she reported her expectations from nursing staff when documenting administration of medications with parameters. She indicated that if a medication is held due to parameters like BP, then she expects the nursing staff to document the BP reading and report it to the physician. Resident #4's eMAR was reviewed with LPN #8 and she confirmed that LPN #7 held the Hydralazine on the dates stated above but failed to document the BP reading. LPN #8 also indicated that she could not find documentation to indicate that LPN #7 reported it to the physician. The concern was discussed with LPN #8 that LPN #7 failed to maintain a complete resident record. She Verbalized understanding and acknowledged the concern. LPN #8 stated, she (LPN #7) will be in later this evening, and we will be talking to her about the concern. 2). On 9/23/25 at 4:19 PM, the Nursing Staff Supervisor (Staff #4) reported that Resident #69 called a family member on 9/19/25 around 10:22 PM after not receiving eye medications. The family member then contacted the facility and spoke with Nurse Supervisor #4. Nurse Supervisor #4 confirmed with agency nurse Staff #5 that the eye drop medication had not been administered. Nurse Supervisor #4 stated that the prescribed eye drop medication was administered at 10:30 PM. On 9/24/25 at 12:58 PM, the Medication Administration Audit Report was requested. On 9/24/25 at 1:30 PM, review of the Medication Administration Audit Report revealed that agency nurse Staff #5 documented the eye drops were administered along with the resident's other medications on 9/19/25 at 9:24 PM. (continued on next page)

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	09/25/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/25 at 3:08 PM, the Director of Nursing (DON) was interviewed. The DON stated it was expected that nurses document medication administration at the time it was given. Additionally, if a nurse signed for a medication they did not administer, the nurse who administered it must correct the medical record and document the event in the progress notes. On 9/25/25 at 10:26 AM, during an interview, the Director of Nursing reported that re-education for the nursing staff had already been initiated regarding proper medication administration documentation and how to correct a medical record documentation error in the electronic health record.

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	09/25/2025

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to properly obtain a resident's signature on an arbitration agreement. This was evident for 1 (Resident #17) of 3 residents reviewed for arbitration agreements.The findings include:An arbitration agreement is a legal document used in long-term care facilities. It requires that disputes or injuries be resolved through private arbitration instead of through the court system. By signing, a resident waives the right to have a judge or jury decide the case. The arbitrator's decision is usually final and cannot be appealed.On 9/22/25 at 3:05 PM, the Surveyor reviewed Resident #17's arbitration agreement dated 4/25/2025. The document was signed by the resident's spouse and states, in part, that any legal dispute, controversy, or claim.shall be resolved exclusively by binding arbitration.and not by a lawsuit or resort to court processes. It further states, The parties understand and agree that by entering this arbitration agreement they are giving up and waiving their constitutional right to have any claim decided in a court of law before a judge and a jury.An advance directive is a legal document or set of instructions that expresses an individual's wishes for future medical care and treatment in case they become unable to make those decisions themselves due to serious illness or injury.A health care power of attorney is a legal document in which an individual (the principal) designates a trusted person (the agent or health care proxy) to make medical decisions on their behalf when they are unable to do so due to illness, injury, or cognitive decline.On 9/23/25 at 9:19 AM, the Surveyor reviewed Resident #17's medical records which included:An advance directive dated 3/31/2025 naming the resident's spouse as primary agent if you cannot or do not want to make your own healthcare decisions.A medical power of attorney dated 3/31/2025 designating the spouse as healthcare agent if I am unable to make my own health care decisions.A Brief Interview for Mental Status (BIMS) score of 15 indicates no or very little cognitive impairment, suggesting that the individual has intact thinking and memory and can likely function normally within their environment.On 9/23/25 at 10:07 AM, the Surveyor reviewed an assessment dated [DATE], which revealed that Resident #17 had a BIMS score of 15. The Surveyor also reviewed a physician certification dated 4/25/25, which documented that the resident was able to:Understand and sign admission documents,Understand the nature and consequences of treatment,Make rational evaluations of treatment options, andEffectively communicate decisions.On 9/23/25 at 11:09 AM, the Surveyor interviewed the Admissions Coordinator (Staff #15). She stated that arbitration agreements are sent out with admission packets and are typically signed by family members through DocuSign (an electronic signature program) prior to admission. She acknowledged that she does not request documentation to confirm legal authority, explaining that they are family. She further stated she was never instructed to confirm that the person signing had the legal right to complete the arbitration agreement.The Surveyor asked Staff #15 to review Resident #17's chart for documentation showing that the resident had lost capacity or had authorized the spouse to sign legal documents. She located the advance directive and POA documents and acknowledged that they only grant authority if the resident is unable to make their own decisions. She stated, I don't see anything in their documents that show that they are unable to make decisions.On 9/23/25 at 11:44 AM, the Surveyor spoke with the Director of Nursing (DON) and the Chief Clinical Officer (CCO). The DON confirmed that Resident #17 had capacity and agreed the findings were concerning. The CCO later stated that the current process was not a legal way to obtain arbitration signatures and acknowledged that residents with capacity have the right to sign their own documents. He stated the facility would retrain Staff #15 following the survey.On 9/24/25 at 10:30 AM, the Surveyor reviewed Resident #17's care plan and found no evidence that the resident had requested the spouse to sign legal documents on their behalf.On 9/24/25 at 12:27 PM, the CCO provided the Surveyor with a copy of Resident #17's personal financial power of attorney, which had been obtained from the spouse that (continued on next page)

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	09/25/2025

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day. The Surveyor explained that this did not negate the lack of appropriate documentation at the time of admission.On 9/24/25 at 12:31 PM, the Surveyor interviewed Resident #17, who stated they did not remember being asked about an arbitration agreement and did not know what it meant.On 9/25/25 at 8:47 AM, the Surveyor interviewed the DON and the CCO. The CCO acknowledged that the financial POA did not give the spouse the right to sign the arbitration agreement and that the facility's current process must be reviewed and revised. He described the presentation of the financial POA as a [NAME] attempt to remove the citation and agreed that residents with capacity must be asked to sign their own arbitration agreements. He stated that the facility will provide education to Staff #15.

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	09/25/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that the facility failed to follow proper infection control procedures. This was evident for 2 (Resident #25 and #67) of 12 residents reviewed for infection control during the recertification survey.The findings include: 1). Transmission-based precautions (TBP) are a set of practices, designed to reduce the risk of infection by breaking the chain of infection through specific modes of transmission, namely contact, droplet, or airborne transmission. These precautions involve specific measures such as proper patient placement, use of personal protective equipment (PPE), and dedicated patient care equipment to prevent the spread of known or suspected infections. Contact precautions are used for infections that spread by direct or indirect contact with the patient or their environment. This involves wearing gloves and gowns for all patient interactions, single-room placement, and using dedicated or disposable patient equipment. Droplet precautions are used for infections that spread via respiratory droplets produced during coughing, sneezing, or talking. This includes wearing a surgical mask for close contact and patient placement in a single room. A review of physician orders for Resident #25 revealed an order, dated 9/20/25, for Contact/Droplet precautions (isolation) due to COVID infection. On 9/22/25 the facility provided a list of residents who required TBP. Resident #25's name was included on the list. Resident #25 resided in room [ROOM NUMBER]. On 9/22/2025 at 2:04 PM an observation of the closed door of room [ROOM NUMBER] was conducted in order to determine if and what type of personal protective equipment (PPE) was needed to enter the room. A cart with a supply of PPE was next to the door, but there was no sign on the door to indicate that the room had Contact/Droplet precautions, or that any PPE needed to be worn to enter the room. On 9/22/25 at 2:06 PM, the Director of Nursing (DON) was interviewed at the nurses' station for room [ROOM NUMBER]. When asked if either resident in room [ROOM NUMBER] required isolation, the DON turned and asked the Infection Preventionist Nurse (Staff #12) who said yes, one of the residents (Resident #25) had an active COVID infection. When the DON was informed room [ROOM NUMBER] lacked any signage to indicate that it was an isolation room and that PPE was required to be worn to enter it, the DON said there should have been a sign. Staff #12 was then observed to make a sign to place on room [ROOM NUMBER]'s door. On 9/22/2025 at 3:12 PM an interview was conducted with the Chief Clinical Officer (Staff #13) to review the concern that room [ROOM NUMBER] lacked an isolation sign although isolation was ordered. He acknowledged the deficiency. 2.) Resident #67 was a newly admitted resident of the facility with a diagnosis of appendicitis with perforation. An interview with Resident #67 was conducted on 9/22/25 at 8:58 AM. During the interview, s/he reported being on an antibiotic for a wound on the abdomen. It was observed during this interview that (continued on next page)

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	09/25/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident was not on Enhanced Barrier Precaution (EBP). There was no sign in or outside the resident's room to indicate such. A brief interview was conducted with the Infection Preventionist (IP) nurse (Staff #12) on 9/22/25 at 2:35 PM. She reported that she reviews resident records to determine if residents need to be on EBP. A list of all residents of the facility who were currently on EBP was requested and provided by Staff #12. Resident #67 was not included in the list. A subsequent interview with Staff #12 was conducted on 9/23/25 at 12:15 PM. During the interview, Staff #12 explained EBP and that there were a lot of misconceptions about it, noting surgical wounds are not part of EBP unless they are infected. Staff #12 was requested to provide the facility's policy on EBP. On 9/23/25 at 1:11 PM, a review of Resident #67's medical record was conducted. The review revealed a medical diagnosis of Infection following a procedure, superficial incisional surgical site dated 9/12/25, and a medical order of antibiotics to be given daily for 7 days indicated for abdominal incision infection with a start date of 9/13/25. On 9/23/25 at 1:14 PM, Staff #12 provided the surveyor with a copy of the facility's EBP policy. A review of the policy with Staff #12 revealed that EBP is indicated to residents with wounds even if the resident is not known to be infected, noting that wounds generally include chronic wounds including but not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcer. A review of Resident #67's medical record was conducted with Staff #12 on 9/23/25 at 1:19 PM. During the review, she confirmed that the resident was not put on EBP and was currently taking antibiotics indicated for an infection on a surgical incision site. Staff #12 indicated that based on the medical records reviewed, the resident should have been on EBP and stated, I should have seen that. The concern that appropriate infection control practices were not used on a resident with infection, as evidenced by Staff #12 failing to recognize and institute interventions including the use of EBP to a resident with an infected surgical wound, was discussed with the Director of Nursing (DON) on 9/25/25 at 12:03 PM. The DON verbalized understanding and acknowledged the concern.