STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215351	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Mays Chapel	12230 Round Wood Road Timonium, MD 21093

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 45131 Based on observation, record review and interviews, it was determined that the facility failed to maintain residents' medical records in a secure location. This was evident for the 4 (Resident #s 8, 25, 53, and 56) of 4 residents' charts observed during the recertification/complaint survey on the 2nd floor nursing unit. Findings include: On 01/09/25 10:35 AM, an observation on the second floor revealed that residents' charts were located on top of a wide filing cabinet in the hallway. The surveyors noted that 4 charts with residents' name and physician orders were found unattended on top of the file cabinet with the physician's order pages flagged (sticking out of the chart) and visible. Resident # 8, # 25, # 53 and # 56's physician orders were visible to the public eye and were not securely stored to ensure confidentiality of the resident's medical records. On 01/09/25 at 10:35 AM, in an interview with Staff #17, Staff #17 was notified of the surveyor's concerns, and she removed the charts. When asked who was responsible for leaving the chart on top of the filing cabinet, she stated the person who wrote the rehab orders. She explained that usually new orders were flagged and placed next to the computer station for the nurse to review.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44441 Based on a facility reported incident MD00204294, observation, record review, and staff interviews, it was determined that the facility failed to protect a resident's right to be free from any type of abuse. This was evident for 1(#28) of 15 residents reviewed for abuse during the facility's recertification/complaint survey. The findings include: On 1/8/25 at 10:26 AM during the initial pool selection, Resident #28 was observed in room sitting in a wheelchair watching TV. Resident #28 is a Korean speaking resident but able to understand and respond with limited English. When asked if everything was ok and if he/she has any concerns, he/she said OK and no problem. On 1/13/25 at 8:09 AM, review of the facilities investigative report MD00204294 had that on 4/2/24 a nurse aide, Geriatric Nursing Assistant (GNA) #23, was screaming and calling Resident #28 stupid and was pushing the resident back into the wheelchair. A review of the video footage confirmed this allegation. The nurse aide, GNA#23, was initially suspended pending investigation, he was later terminated and reported to the board of nursing. The Director of Nursing (DON) in an interview on 1/13/25 at 8:16 AM was asked the expectations for following up on allegations of abuse. She stated that when a resident makes an allegation, if it is an employee, the expectation is for them to go directly to a supervisor to report it or to the DON or Nursing Home Administrator (NHA) so an investigation can be started. She explained further that investigations are conducted following the facility's investigative policy and procedures. On 1/14/25 at 12:40 PM In another interview with the NHA, he stated that a thorough investigation for an allegation of this abuse was done. The investigation included talking to staff that were present including the alleged perpetrator, the resident, possibly anyone else that could be affected and anyone who would have some type of data on the alleged abuse. Camera footage review and key witness statements confirmed this allegation of abuse.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 47200 Based on interview and record review it was determined the facility failed to ensure a thorough review of background check results during the hiring process for a geriatric nursing assistant who had been employed with the facility for approximately one year. This was evident for 1 (GNA #16) out of 1 previously employed geriatric nursing assistant which was reviewed during investigation of an allegation of abuse for facility reported incident #MD00206160 during the facility's recertification/complaint survey. The findings include: On 1/10/25 at approximately 10:29AM the surveyor conducted a review of the employment file of Geriatric Nursing Assistant (GNA) #16 which revealed there was no background check present within the file, at which time the surveyor requested from the facility Administrator that a copy be provided. On 1/10/25 at approximately 12:00PM the surveyor reviewed the results of the background check documented as completed on 12/11/23 for GNA #16 which revealed the following documented information: second degree assault offense, guilty disposition, and sentencing details. On 1/15/25 at approximately 1:00PM the surveyor conducted an interview with the facility Administrator who reported GNA #16 was hired as a nurse aide in training by the facility and then during their employment with the facility, acquired their GNA certification through an approved program. When the surveyor inquired to the facility Administrator as to further details about the hiring of GNA #16 who had a resulted background check, they reported they did not have further information at this time and would need to get back to the surveyor. At this time, the surveyor offered opportunity for the Administrator to provide any and all supporting documentation as to the continued hiring of GNA #16 and the human resources recruiter contact information. On 1/21/25 at 11:50AM the surveyor conducted an interview with the facility Administrator who reported they were not made aware of the background check results regarding GNA #16 who was no longer employed with the facility. When the surveyor inquired as to the facility's process for screening for employment to the Administrator, they reported that when a background check results in a finding, they were expected to be notified and a discussion surrounding eligibility would take place prior to the applicant moving forward through the employment process. At this time the surveyor requested an interview with Human Resources department staff. At this time, the surveyor shared their concern with the facility Administrator who acknowledged and confirmed understanding of the concern. On 1/21/25 at 11:52AM the surveyor conducted an interview with Human Resources Director #18 who confirmed they were not made aware of the result of GNA #16's background check by Human Resources Recruiter #19 who is no longer in the recruiter role. After surveyor intervention, Human Resources Director #18 reported to the surveyor that since the situation had been brought to their attention, they were performing an audit to ensure no other employees background checks had a similar issue. At this time, the surveyor shared their concern with Human Resources Director #18 who acknowledged understanding of the concern. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/21/25 at 2:45PM the surveyor reviewed the concern during the exit conference with the facility's Administrator and Director of Nursing.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47200 Based on interview and record review it was determined the facility failed to ensure the abuse, neglect, exploitation and misappropriation policy was developed to include the required necessary reporting and response timeframes. This was evident during the surveyor's review of 1 out of 1 policy the facility had in place to prohibit and prevent abuse, neglect, expolitation and misappropriation during the facility's recertification/complaint survey. The findings include: On 1/8/25 at 7:59AM the surveyor conducted an entrance conference with the facility's Administrator at which time the surveyor requested a copy of the facility's abuse prohibition policy and procedures. On 1/10/25 at 12:15PM the surveyor conducted a review of the facility's abuse prohibition policy and procedures and noted the following information present in the reporting requirements section of the policy which contained numerous statements and included innaccurate reporting timeframes: The administrator will direct that a report of an allegation of abuse, exploitation, neglect, or unknown injury be faxed or emailed within 24 hours to the Office of Health Care Quality, In cases of reasonable suspicion of a crime the facility must notify OHCQ and one or more law enforcement agencies, Allegations of sexual abuse must be reported to the State Agency and law enforcement within 2 hours, The facility will report within two hours after forming the suspicion, if the events that caused the suspicion result in serious bodily injury, or not later than 24 hours if the events that caused the suspicion do not result in serious bodily injury, If the result that causes the suspension results in serious bodily injury, the individual shall report the suspension immediately, but not later than two hours after forming the suspicion, If the events that cause the suspension do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion, Other agencies, if any, that Administrator may need to notify could include law enforcement agencies, licensing boards and the local ombudsman. Further review of the policy revealed the following information under the investigation section of the policy: See policy and procedure on Investigation of Abuse, Neglect, or Injury of Unknown Origin. Continued review of the policy revealed the following information under the identification section of the policy: Staff will document the allegations on an occurrence report. On 1/10/25 at 12:30PM the surveyor requested all policies, procedures, and protocols related to abuse, neglect, exploitation, and misappropriation and investigation thereof, to be provided to the surveyor, and in response, the facility's Administrator then referred to the previously provided policy and stated: This is the policy we use. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/10/25 at 1:03PM the surveyor conducted an interview with the facility Administrator who confirmed this policy was the only policy in place surrounding abuse, neglect, exploitation and misappropriation, and there were no other policies or procedures that existed to provide to the surveyor. When the surveyor inquired as to the policy referencing a policy and procedure surrounding investigation, the Administrator states the policy was referring to itself, that there was no other investigation policy or procedure. When the surveyor inquired as to occurrence reports that are utilized by staff to document allegations, the Administrator confirmed the facility does not use occurrence reports. At this time, the surveyor shared their concerns with the facility Administrator who stated to the surveyor: I understand your concerns. The concern was again shared with the facility Administrator and Director of Nursing at the time of the exit conference on 1/21/25 at 2:45PM.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45131 Based on interview and record review it was determined the facility failed to ensure: 1) timely reporting of a serious injury of unknown source (Residents #9, #82, #6), and 2) timely reporting of an allegation of abuse (Resident #81). This was evident for 4 (MD#00194057, MD#002044306, MD#00212835, #MD00181864) of 20 facility reported incidents reviewed during the facility's recertification/complaint survey. Findings Include: Situation, Background, Assessment, and Recommendation (SBAR) is a communication tool that helps healthcare professionals to share information about a patient's condition in a concise manner. 1) On 01/09/25 at 03:23 PM, a review of complaints MD#00193619 and #MD#00193826 submitted to the Office of Health Care Quality (OHCQ) alleged that on 5/31/23 Resident #9 was hit by a male aide, and the resident suffered blunt force head trauma to the entire left side of the forehead. A facility reported incident MD#00194057 alleged that the Resident #9 sustained an injury of unknown origin on 5/31/23. On 1/13/25 at 1:00 PM, a review of the facility's investigation file revealed that Resident #9 sustained an injury to the left side of the forehead/face on 5/31/23 at 8:00 PM; however, the facility reported the incident to OHCQ on 7/5/23 at 2:11 PM. On 1/13/25 at 1:52 PM, in an interview with Staff #27, the surveyor asked about the event of 5/31/23 and after reviewing the documents, she stated that they determined that Resident #9's injury was from the bedrail. On 1/14/25 at 12:50 PM, in an interview with the Nursing Home Administrator (NHA), he was asked about the delay in the reporting time for injury of unknown origin related to Resident #9 for the date of 05/31/23. The NHA stated that the patient representative expressed their concerns to the police and the ombudsman suggested that a facility self-report should be submitted to the OHCQ. He stated that the facility determined that the injury was from the bedrails as stated on the SBAR. The surveyor asked if there was a witness to Resident #9's injury, after further review of the documentation provided to the surveyor, he acknowledged that the injury was unwitnessed. He stated that they were interpreting the SBAR as a known origin injury from the bedrails and therefore they did not report the incident as required. 2) On 01/10/25 at 09:32 AM, a review of the facility reported incident form related to MD#002044306 revealed that on 4/2/24 a GNA noted a bruise on the Resident #82's arm; however, the GNA later stated that she thought it was an old bruise; therefore, the GNA failed to report the findings at that time. The facility's investigation report stated that on 4/3/24 near 09:00 AM, a second GNA notified the nurse about Resident #82's left arm bruise. On 4/3/24 near 09:45 AM the administrator was notified; however, OHCQ was notified 4/3/24 at 11:46 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/10/25 at 11:25 AM, a review of Staff #28 (LPN) progress notes on 4/3/24 at 09:00 AM revealed that Staff#28 observed that Resident #82 had a mixture of black/Red/Brown discoloration to the left lateral forearm extended to the right mid arm(back). Staff #28 documented that she was unsure of the cause of injury. On 1/10/25 at 12:00 PM, in an interview with Staff #28, she was asked about the facility's process to report injuries of unknown origin, and she stated nurses are to report any issues to the administrator immediately, complete a skin assessment, review meds, complete the SBAR, and notify the supervisor, doctor and the resident's representatives. The surveyor asked her about the specific incident, and she stated that she does not remember the incident related to Resident #82. On 1/16/25 at approximately 2:53 PM, the NHA was notified that the facility failed to report the above-mentioned incident in a timely manner. 47200 3) On 1/17/25 at 2:39PM the surveyor conducted a review of the facility's complete investigation file for facility reported incident MD#00212835. Review of the initial report made by the facility documented the report was made for an injury of unknown source for Resident #6. Surveyor review of the final radiology results report for Resident #6 revealed their x-ray results detailing serious injury was reported to the facility on [DATE] at 11:15AM. Review by the surveyor on 1/21/25 at 8:28AM revealed the facility's initial self report for serious injury was documented as having been made on 12/16/24 at 11:00AM to the Office of Health Care Quality, however, review of MD#00212835 indicated the report was made to the Office of Health Care Quality on 12/18/24. On 1/21/25 at 8:56AM the surveyor conducted an interview with the facility's Administrator and inquired as to why the serious injury of unknown source was not reported timely, to which they replied they would have to review the file and get back to the surveyor. On 1/21/25 at 9:04AM the surveyor conducted an interview with the facility Administrator who confirmed with the surveyor that the report was made late. Review by the surveyor on 1/21/25 at 9:07AM of email documentation provided by the Administrator confirmed the initial report was submitted to the Office of Health Care Quality on 12/18/24 at 2:23PM, approximately more than 51 hours after the facility received notification of the x-ray result for Resident #6. At this time, the surveyor shared their concern with the Administrator who acknowledged and confirmed understanding of the concern. On 1/21/25 at 2:45PM the surveyor reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) On 1/14/25 at 12:38PM the surveyor conducted a review of the facility's complete investigation file for facility reported incident #MD00181864 in which a report was made by the facility to the Office of Health Care Quality for an allegation of abuse for Resident #81. Review of the initial self report form contained within the file revealed documentation that an allegation of abuse was made to the facility's social worker by Resident #81 on 8/8/22 at 2:15PM. Continued review of the contents of the facility's complete investigation file revealed a resident complaint form completed by Licensed Practical Nurse #21 on 8/7/22 which documented the allegation of abuse made to them by Resident #81 and their subsequent action taken to notify the facility's Director of Nursing. On 1/14/25 at 2:32PM the surveyor reviewed the email confirmation documentation provided by the facility Administrator which indicated the initial self report was not sent to the Office of Health Care Quality until 8/8/22 at 6:32PM. On 1/14/25 at 2:32PM the surveyor conducted an interview with the facility Administrator who acknowledged understanding of the concern, and no further documentation was provided prior to surveyor exit from the facility. On 1/21/25 at 2:45PM the surveyor again reviewed the concern during the facility's exit conference with the Administrator and Director of Nursing.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47200 Based on interview and record review it was determined the facility failed to: 1) ensure measures were taken to protect a resident (Resident #81) during an investigation of an allegation of abuse and 2) thoroughly investigate an allegation of abuse. This was evident for 1 (#MD00181864) out of 20 facility reported incidents reviewed during the facility's recertification/complaint survey. The findings include: On 1/14/25 at 12:38PM the surveyor conducted a review of the facility's complete investigation file for MD#00181864 which revealed an allegation of staff to resident abuse was made by Resident #81 to Licensed Practical Nurse (LPN) #21 on 8/7/22 which was documented on a resident complaint form which included the allegation made by the resident to LPN #21 and the action taken by LPN#21 to notify the facility's Director of Nursing. On 1/14/25 at 2:22PM the surveyor conducted an interview with the facility Administrator and inquired as to if the physical appearance/description of the alleged perpetrator which was provided by Resident #81 to LPN #21 on 8/7/22 as documented on the resident complaint form, fit the description of LPN #29, to which they confirmed: yes. Further review of the resident complaint form revealed Resident #81 identified the alleged perpetrator's attire as a blue uniform, identified them as a male nurse, and identified the timeframe of the alleged event as sometime last week. Surveyor review on 1/14/25 at 2:52PM of the facility Administrator's documentation of an interview conducted with Resident #81's family member on 8/8/22 revealed they believed Resident #81 was referring to LPN #29 as the alleged perpetrator. The facility Administrator documented that this was rather interesting because LPN #29 was the one who was taking the notes from Resident #81 in regards to the description (of the alleged perpetrator). Further review of the complete investigation file revealed two similar statements which were hand written and signed by LPN #29 with two different dates, one was dated 8/7/22, and one was dated 8/9/22, and included a differing description of the alleged perpetrator in comparison to the initial description provided on the resident complaint form. Review of LPN #29's statement described how they had heard about the abuse allegation and went to the resident's room to collect more information about the allegation or so to say, and LPN #29 documented a description of the alleged perpetrator and a timeframe of when the allegation was to have occurred, and further detailed that LPN #21 whom the resident reported the allegation to is throwing my name in this incident purportedly that the description matches LPN #29, the nurse. The surveyor noted that action had not been taken by the facility to immediately protect the resident in response to an allegation of abuse which was made on 8/7/22. Review of the staffing schedules revealed LPN #29 had worked approximately 7 shifts within the facility during the initial allegation timeframe specified by the resident, and continued to work once the allegation was made, to include conducting an interview with the resident. On 1/14/25 at 3:00PM the surveyor conducted an interview of the facility Administrator who could not confirm whether the facility had taken any measures to protect the resident in regards to LPN #29, although LPN #29 appeared to be the only male nurse on the schedules for the unit in which the resident resided during the alleged timeframe. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 3:20PM the surveyor reviewed the employment file of LPN #29 which revealed the uniform requirement for nurses was documented that they dress in blue scrubs. The surveyor confirmed with the Administrator that at the time of the allegation of abuse, nurses were required to dress in blue scrubs.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 44441 Based on record review and staff interviews, it was determined that the facility failed to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing. This was evident for 1 (#55) of 2 residents reviewed for hospitalization during the recertification/complaint survey. Findings Include: On 1/21/25 at 8:41AM review of Resident #55's medical records revealed that s/he was hospitalization on 3 different dates in 2024 which were 1/16/24, 8/25/24 and 10/12/24. Further review did not show that the resident or their representatives were given a written notification of the transfer. In an interview with the Director of Nursing on 1/21/25 at 11:47 AM, she was asked about the notification process. She explained that the families are notified by phone calls or verbally to let them know that their loved ones are being sent out and that facility staff are required to document who they notified. When asked about sending written notifications, she indicated that there was no written notification and that the facility does not send written notifications. She was made aware that this was a concern.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49304 Based on review of medical records and interview with facility staff, it was determined that the facility failed to provide a baseline care plan summary to residents. This was evident for 1 (#79) of 7 residents reviewed for baseline care plans during the recertification/complaint survey. The findings include: On 1/13/25 at 1:58 PM review of Resident #79 's progress notes did not reveal any notes referring to the resident's Baseline Care Plan (BLCP). On 1/13/25 at 2:19 PM review of the medical record revealed Baseline Care Plan v1.1 - V 1: 78 days overdue - 10/27/2024 documented in red letters. On 1/13/25 at 3:03 PM in an interview with the Director of Nursing (DON), she stated there was not a BLCP for Resident #79. During the interview, she stated she was not sure why it was missed. The resident did come on a Friday after we left for the day, but she stated she was not sure why it was not caught on Monday.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45131 Based on record review and staff interview, it was determined that the facility failed to ensure the care plan was reviewed and updated by the interdisciplinary team after the care plan meeting. This was evident for 1 (Resident #7) of 2 residents reviewed for the use of a feeding tube during the recertification/complaint survey. Findings Include: A gastrostomy tube (G-tube) is a tube that is surgically inserted through the abdomen and brings nutrition directly to the stomach. The Minimum Data Set (MDS) is a standardized comprehensive assessment tool that measures health status in nursing home residents. On 01/09/25 09:20 AM, record review revealed that Resident #7 had 4 separate incidents of G-tube dislodgement between the months of July 2024 and October 2024. On 2 of 4 G-tube dislodgment, the resident was transferred to the emergency room for further evaluation. On 1/15/25 at 11:45 AM Interview with Staff #6, he stated that the unit manager is responsible for updating the care plan. He also stated that care plan updates are usually done quarterly with MDS assessment or as needed. On 01/21/25 09:40 AM, a review of the care plan meeting notes in July 2024 revealed that the G-tube dislodgment was discussed; however, the facility failed to update Resident #7's care plan to reflect how the facility planned to care for the resident and prevent future dislodgement of the G-tube. On 01/21/25 at 10:07 AM, in an interview with Staff #1, she stated that the Unit Managers or Director of Nursing usually updates the care plan. The surveyor asked Staff #1 for an explanation on why the G-tube dislodgement was not found on the care plan until 10/2/24 and she stated that she updated the resident's care plan when she realized that the G-tube dislodgement was not addressed on the care plan as required.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44441 Based on a facility report MD00205422, record review, and staff interviews, it was determined that the facility failed to provide and utilize an assistive device to transfer a resident as ordered. This was evident for 1(Resident #281) of 20 facility reported incidents reviewed during the recertification/complaint survey. The findings include: On 1/16/25 at 4:00PM review of MD00205422 had that on the night of 5/6/24, Resident #281 needed their air mattress installed. The aide was going to transfer resident from bed to wheelchair so that a new mattress could be placed. Resident stated that s/he was supposed to be transferred via Hoyer due to surgery but was not. Resident stated that the transfer was painful, their left leg jammed into the bed and their heel hit the floor hard. Resident stated they were having pain in their body during repositioning. Review of the resident's care plan on 1/17/25 at 10:50AM with initiation date of 5/6/24 documented that resident had a left leg fracture related to fall with interventions to follow orders for non-weight bearing to the affected leg. Further review of the Physical Therapist evaluation dated 5/5/24 on 1/17/25 at 1:55 PM coded Resident #281 as a total assist requiring substantial/maximal assist (with 2 people) with Chair/bed -to-chair transfer. In an Interview with staff #14, the rehab director on 1/17/25 at 12:34 PM, she explained that a total assist meant the resident required a Hoyer lift (transferring device) to transfer. On 1/17/25 at 1:55 PM: the Director of Nursing (DON) confirmed that resident was a total assist and should not have been transferred without the Hoyer lift. She was made aware that this was a concern

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 47200 Based on record review and interview it was determined the facility failed to ensure the monitoring of a medication for a resident. This was evident for 1 (Resident #4) out of 5 residents reviewed for unnecessary medications during the recertification/complaint survey. The findings include: On 1/16/25 at 12:12PM the surveyor reviewed the medical record for Resident #4 which revealed the January 2025 medication administration record (MAR) documented the following order dated as beginning on 7/27/24 was present: Metoprolol Succinate ER Tablet 25mg, give 1 tablet by mouth in the morning for HTN (Hypertension) hold medication if pulse <60 and/or systolic blood pressure <100mmhg. Further review of the documentation revealed various staff had signed off on daily administration of the medication from 1/1-1/16/25, however, the fields for blood pressure and pulse to be recorded and input were observed to not be completed. On 1/16/25 at 12:44PM the surveyor conducted an interview with Licensed Practical Nurse (LPN) #20 who was assigned to the care of Resident #4. When the surveyor inquired as to where the values were input for monitoring of blood pressure and pulse when a resident has a medication ordered with parameters, they reported to the surveyor that usually they have access to an automated link to put the values in, but in this case, that link was not present. On 1/16/25 at 12:51PM the surveyor conducted an interview with Registered Nurse (RN) #17 who reported to the surveyor that if a medication has parameters ordered, it always has a box to input vital signs whether the medication is being held or not. On 1/16/25 at 12:54PM the surveyor conducted an interview with the Director of Nursing (DON) who reported to the surveyor that their expectation was for staff to document the vital signs for a medication with parameters in the medical record even if the medication is not being held. At this time, the concern was shared with the DON and Unit Manager #6, who both acknowledged and confirmed understanding of the concern.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47200 Based on record review and interview it was determined the facility failed to ensure the monitoring of a psychotropic medication. This was evident for 1 (Resident #4) out of 5 residents reviewed for unnecessary medications during the facility's recertification/complaint survey. The findings include: On 1/16/25 at 9:16AM the surveyor reviewed the medical record for Resident #4 which revealed a recommendation was made upon completion of the resident's medication regimen review by pharmacy for the month of November, 2024, however, there was no documentation of what that recommendation was. At this time, the surveyor notified the facility's Director of Nursing (DON) that the recommendation was not located within the resident's medical record, and requested a copy of the recommendation. On 1/16/25 at 9:30AM the surveyor conducted an interview with the DON who confirmed with the surveyor that Resident #4 was not on the no recommendations made list for November 2024 and they were unable to locate what recommendation was made. The DON stated to the surveyor: I'll check with the pharmacy and then provide further information to you. On 1/16/25 at 9:52AM the DON provided the medication regimen review recommendation for Resident #4 which revealed a nursing recommendation was made by pharmacy dated 11/2/24 for the institution of side effect monitoring on the medication administration record (MAR) for Seroquel, an antipsychotic medication. At this time, the surveyor conducted an interview with the DON who confirmed that the recommendation was missed, they are putting it in now. The DON further reported to the surveyor that behavior monitoring was being performed by Geriatric Nursing Assistants (GNA's), so behaviors are being monitored. At this time the surveyor shared their concern with the DON who acknowledged and confirmed understanding of the concern. On 1/16/25 at 12:12PM the surveyor reviewed the medical record of Resident #4 which revealed there was no side effect or behavior monitoring present on the January 2025 MAR until it was instituted beginning 1/16/25. On 1/16/25 at 12:54PM the surveyor shared the concern with Unit Manager #6 and the DON, who both acknowledged and confirmed understanding of the concern. On 1/21/25 at 2:45PM the surveyor again shared the concern during the facility's exit conference with the facility Administrator and Director of Nursing.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44441 Based on a complaint incident #MD00191927, record review and interviews, it was determined that the facility failed to ensure that a resident was free from significant medication errors. This was evident for 1 (Resident #86) of 10 complaints reviewed during the facility's recertification/complaint survey. The findings include: On 1/17/25 at 8:43AM review of a complaint incident MD00191927 had that a resident's family member found a pill that did not belong to the resident on their bed when the resident got up to go to the bathroom. The resident also stated to the family member that he was given 14 pills the evening of 4/15/2023 and felt weak with numerous body aches. The family member took a picture of the pill, turned it in and reported to Staff #15, the evening shift supervisor. Further investigation revealed that the medication was one of the pills taken by the resident's roommate who was on multiple pills. Review of the resident medication for the month of April 2023 on 1/17/25 at 8:46 AM revealed that Resident #86 only takes 3 pills in the morning and 1 at night. The pill found on the resident's bed on identification was not one of his prescribed medications. The pill was one of many prescribed for his roommate who was on 10 pills in the morning and 10 at night. On 1/17/25 at 9:05AM in a phone interview with Nursing Supervisor #14, she stated that Resident #86's family member brought the pill to her and said they found it on the resident's bed. That the said medication did not belong to the resident. Staff #14 said she took the pill, checked it out and it matched one of the pills that the roommate was on. She then reported the incident to the Director of Nursing (DON) and the Nursing Home administrator (NHA) for further investigation. She indicated that she believed Resident #86 got medications meant for their roommate. She was made aware that this was a concern.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44441 Based on a facility reported incident, complaint, observation, record review and interview it was determined the facility failed to: 1) secure residents medication properly, evidenced by leaving medications unsupervised at the bedside, resulting in a foreign object accidental ingestion. 2) ensure a medication cart was locked while unattended. This was evident for: 1) 1 (Resident #282) of 30 intakes reviewed, and 2) 1 out of 4 medication carts located on the second floor of the facility, during the facility's recertification/complaint survey. The findings include: 1.) Gastro- Intestinal (GI) tract is the organ that food and liquids travel through when they are swallowed, digested, absorbed, and leave the body as feces. On 1/14/24 at 9:26 AM review of a facility reported incident MD00208443 and a complaint MD00208850 had that Resident #282 reported swallowing what looked like a horse-pill in his medicine cup. The nurse on duty verified she had left a lancet, a device used to obtain blood for testing blood sugar in the resident's medicine cup. The nurse turned around to get some water, when resident swallowed it with the pills before she could stop them. Provider was immediately notified, and resident was sent out to the emergency room for further evaluation following ingestion of foreign object. The allegation was verified as there was visualization of small linear foreign body in resident's gastro-Intestinal (GI) tract from hospital x-ray report. Resident #282 was discharged from the hospital with the recommendation to report and monitor for complaints of abdominal pain, nausea or vomiting. Resident #282 did not suffer any adverse effects from the incident, and did not voice any complaints after the incident on subsequent days. In an interview with Licensed Practical Nurse #13, the alleged perpetrator, on 1/15/25 at 7:29AM she recounts that she had Resident #282's medications prepared to take in the room. She had the pills in a medicine cup and placed the lancet to check residents blood Sugar in the same cup. She then placed the medicines at the resident's bedside, noticed that there was not enough water for the resident to take his pills. She went to get the water, leaving the pills at the resident's bedside. When she got back, the resident said or asked, what is this horse pill that I swallowed, that was when she realized that the resident had swallowed the lancet with the pills. She notified the providers and got orders to send resident out to the hospital for evaluation. On 1/14/25 at 9:31AM the Director of Nursing agreed that the staff should not have left the medication unsupervised at the resident's bedside. She was made aware that this was a concern. 47200 2.) During the surveyor's initial tour on 1/8/25 at 8:34AM a medication cart was observed to be unlocked and unattended with the lock mechanism protruding outward. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at approximately 8:56AM, upon continued further observation of the cart, the surveyor was able to openly access the medication cart drawers containing various supply of resident medications. On 1/8/25 at approximately 8:56AM the surveyor conducted an interview with Licensed Practical Nurse (LPN) #20 who confirmed with the surveyor that the facility's expectation was for medication carts to be closed and locked. At this time LPN #20 proceeded to show the surveyor how they are expected to lock the medication cart. The surveyor observed LPN #20 depress the locking mechanism on the cart. The surveyor shared their concern with LPN #20 who confirmed and acknowledged understanding of the concern. On 1/8/25 at 9:08AM the surveyor shared the concern with the facility Administrator and the Director of Nursing, who both confirmed understanding of the concern. On 1/21/25 at 2:45PM the surveyor reviewed the concern during the facility's exit conference.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45131 Based on observation and staff interview, it was determined that the facility failed to ensure that stored food items were labeled and were not expired. This was evident during the initial tour of the food service department during the recertification/complaint survey. Findings include: On [DATE] at 08:10 AM, an observation during the kitchen tour revealed that there were: a 3 lbs can of strawberry topping with a used by date of [DATE]; a 6 lbs can of navy bean with unknown expiration date; 2 undated open bags cinnamon swirl bread with raisin and 2 undated open bags of hamburger buns. On [DATE] at 08:35 AM, an observation of the walk-in refrigerator revealed 2 open undated bags of mixed salad; an open undated bag of turkey breast deli meat, and a large open plastic container of cherry topping prepared on [DATE]; however, there were no expiration dates on the above-mentioned items. On [DATE] at 08:35 AM, in an interview with Staff #15, he stated that the open, undated bread were usually used within the day and they don't usually have left overs. He was also unable to clarify the expiration date on the above-mentioned canned goods. Also, he was unable to provide the expiration dates for the above-mentioned walk-in refrigerator items.

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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. 45131 Based on record review and interview, it was determined that the facility failed to ensure that the resident medical records provided during the survey process contained sufficient information to identify the care provided to each resident. This was true for 2 (Resident #7 and Resident #82) of 18 resident medical records reviewed in the survey sample during the recertification/complaint survey. Findings Include: A gastrostomy tube (G-tube) is a tube that is surgically inserted through the abdomen and brings nutrition directly to the stomach. Situation, Background, Assessment, and Recommendation (SBAR) is a communication tool that helps healthcare professionals to share information about a patient's condition in a concise manner. 1) On 01/09/25 at 09:20 AM, a review of Resident #7's progress notes written on 10/4/24 at 8:45 AM, stated that the resident's G-tube was dislodged, and the nurse received an order to transfer resident to the emergency room ; however, there was no additional documentation to suggest that the nurse conducted a thorough assessment of the resident following the incident and there was also no documentation to suggest that the resident's representative was notified of the hospital transfer. On 01/21/25 at 10:27 AM, in an interview with the Director of Nursing (DON), the DON was asked about Resident #7's nursing assessment for the above mentioned incident, and she stated the SBAR was to be completed by the nurse; however, it was not done within the required timeframe and when we realized that the SBAR was missing, it was too late to enter a late entry assessment. 2) On 1/10/25 2:18 PM, a review of a complaint MD#00181494 alleged that on 7/28/22 the Resident #82 suffered an unwitnessed fall and was subsequently found to have multiple fractures. On 1/10/25 2:20 PM, a review of Resident #82's progress notes revealed that on 7/28/22 the resident was found sitting on the bathroom floor, no injury noted upon a physical nursing assessment; however, the resident complained of right leg pain, the resident was medicated with Tylenol and returned to bed. On 7/29/22 the medical records showed that the resident complained of leg pain and had limited range of motion and was medicated with Tylenol at 09:27 AM; however, there was no documentation in the medical record to show that the nurse conducted a post pain medication assessment before 1:47 PM on 7/29/22 and the post pain medication assessment was documented as ineffective. The next progress note in the resident's medical record was on 7/29/22 at 3:46 PM which stated that resident was transferred to the emergency room at 3:13 PM per order of facility medical director. X-ray confirmed fracture of the right femur. The resident medical record failed to have evidence that the resident was reassessed for pain after an hour of the Tylenol administration at 09:27 AM. On 01/17/25 08:25 AM, in an interview with Staff #20 (License Practical nurse), she was asked about the expected timeframe for the reassessment of a pain medication's effectiveness, and she stated that the medication should be reassessed an hour after administration. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/21/25 01:00 PM, in an interview with the Director of Nursing (DON), the DON was asked about the expectation for post pain medication administration reassessment, she stated that the reassessment is to be completed after an hour of administration. The DON was notified that the documentation showed that Resident #82's pain was not assessed within 1 hour of pain medication being administered on 7/29/22. She was asked by the surveyor to provide any additional documentation to support that the resident was reassessed after an hour. On 01/21/25 at 1:33 PM, the DON provided a print out of a correspondence from an electronic medical communication service/system between nurses and practitioners, which showed that the resident was reassessed by the nurse at 10:10 AM and additional orders were obtained from the physician; however, this information was not transferred to the resident's medical record to accurately reflect all the interventions provided during the care of this resident. On 01/21/25 at approximately 3:00 PM during the exit conference, the DON and the Nursing home administrator were made aware that Resident #82's medical records failed to include pertinent information related to the resident's overall care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47200 Based on observation, interview and medical record review it was determined the facility failed to: 1) ensure the accuracy of infection control signage, and 2) ensure all employees' required immunizations were up to date, as it relates to infection prevention and control. This was evident for: 1) 5 of 83 resident occupied rooms at the time of the surveyor's initial tour, and 2) 3 (GNA #22, GNA#23, GNA#24) of 5 employees reviewed, during the facility's recertification/complaint survey. The findings include: 1.) On 1/8/25 at approximately 7:30AM surveyors observed signage present at the front reception desk indicating the facility was currently in outbreak status. On 1/8/25 at 7:59AM the surveyor conducted an entrance conference with the facility Administrator, at which time they informed the surveyor of positive resident cases of Covid 19 infection within the building which included Residents #64, #41, #8, and #69. On 1/8/25 at 9:40AM the surveyor observed the following infection control precaution signage: Room of Residents #64 and #41: special droplet/contact precautions, Room of Residents #51 and 65: droplet precautions, Room of Residents #32 and #50: droplet precautions, Room of Residents #55 and #56 had a specialized personal protective equipment container with no signage present, and Room of Residents #69 and #8: droplet precautions. On 1/8/25 at approximately 9:40AM the surveyor conducted an interview with the facility Administrator who confirmed with the surveyor that the only two rooms with Covid 19 positive residents were the rooms of Residents #64, #41, #8, and #69. On 1/8/25 at 10:08AM the surveyor conducted an interview with the Director of Nursing (DON) who reported the following in response to the surveyor's inquiry regarding why the room of Resident #64 and #41 had special droplet/contact precaution signage vs. the room of Residents #8 and #69 which had only droplet precaution signage: Staff should be fully gowned and gloved, with an N-95 mask, and faceshield in the rooms (of Residents #64, #41, #8, and #69.) When the surveyor inquired to the DON as to the differences in precaution signage and what was their expectation of the signage to be used for Covid 19 positive residents they responded: No that is an old one, special contact precautions, I can go get it for you, it's neither of those, the first one should be more accurate, but we made them new and more explanative. At this time the surveyor requested for a dual observation with the facility DON and Administrator, as it remained unclear as to what infection control signage was expected to be utilized to prevent spread of infection. On 1/8/25 at 10:15AM the surveyor conducted a dual observation of the infection control precaution signage on the second floor nursing unit with the facility Administrator and DON. At this time, the observation was made that the room of Residents #8 and #69 had no signage on the door and a droplet precaution sign was laying on a bedside table within the hallway of the nursing unit with a face shield laying on top of it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 10:18AM the surveyor conducted an interview with the DON who reported to the surveyor that they would fix the signage and would be removing the droplet precaution signage from several room doors. On 1/8/25 at approximately 10:21AM the surveyor observed the DON removing the droplet precaution signage that was present on several room doors and they stated the following to the surveyor: I'm going to go get the Covid signs. Upon the DON's return with the signage they informed the surveyor that the special contact/droplet precautions signage was to be in place for Covid 19 positive residents. The DON further reported to the surveyor that the typical Infection Preventionist for the building was currently on leave. On 1/8/25 at 11:37AM the surveyor reviewed the resident matrix document completed and provided by the facility to the survey team in response to the 1/8/25 entrance conference documentation requests. Review of the resident matrix revealed all respiratory illnesses were not captured, and no transmission based precautions were identified as in place according to the document. Upon further surveyor request, the facility Administrator revised the resident matrix and provided the surveyor with a copy which captured that transmission based precautions were to be in place for Residents #64, #41, #8, and #69, however, not for Residents #51, #65, #32 and #50. On 1/16/25 at 2:53PM the surveyor reviewed the concern with the facility Administrator who acknowledged and confirmed understanding of the concern. On 1/21/25 at 2:45PM the surveyor again shared the concern during the facility's exit conference with the Administrator and DON. 49304 2.) On 1/16/2025 at 8:28 AM, 5 employees' files were reviewed. The review included TB (tuberculosis) screenings and immunizations and revealed Geriatric Nursing Assistant (GNA #22) did not have a documented Tdap (tetanus, diphtheria, pertussis) on file, GNA #23 did not have a documented influenza or Tdap on file, and GNA #24 did not have a documented influenza, MMR (measles, mumps, rubella), or Tdap on file. On 1/17/25 at 9:06 AM the survey team requested evidence of the above mentioned immunizations, and all policies and procedures related to required employee immunizations. On 1/17/25 at 9:10 AM the Nursing Home Administrator (NHA) provided the 2 page policy, Employee Medical Records. Review of the document revealed: 1. The medical record will contain, as a minimum: d. Hepatitis B consent vaccination form; g. a copy of MMR and Varicella vaccination records; screening tool, PPD skin test results, or negative chest x-ray for Tuberculosis screening, i. a copy of current influenza and COVID vaccine data. The policy made no mention of the Tdap (Tetanus, Diphtheria, Pertussis) immunization. On 1/17/25 at 10:35 AM in an interview with the NHA he stated he did not have a Tdap for GNA #23. He provided the survey team with GNA#23 and GNA #24's influenza documentation. During the interview he stated he still had a call out to the Infection Preventionist for GNA #24's Tdap and MMR and was waiting to hear from the agency for GNA #22's Tdap. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215351	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Mays Chapel	12230 Round Wood Road Timonium, MD 21093

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25 at 12:51 PM in an interview with the Director of Nursing (DON) when asked if TDap was a required immunization for employees she stated she would have to ask HR (Human Resources) and get back to the survey team. On 1/17/25 at 1:51 PM in a follow up interview with the DON when asked if Tdap is required for employees she stated it was a required immunization for employees. During the interview when asked why it is not in the facility's Employee Medical Records Policy, she stated she did not have an answer for that and could only revise the policy. On 1/21/25 at 9:18 AM the survey team made a 2nd request to the NHA for evidence of GNA#22's Tdap and GNA #24's Tdap and MMR. On 1/21/25 at 9:56 AM in an interview with the NHA he stated he did not have a Tdap for GNA #22 nor a Tdap or MMR for GNA#24.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49304 Based on review of resident records and facility policy and interview with facility staff, it was determined that the facility failed to ensure that each resident was offered a pneumococcal vaccine. This was evident for 1 (Resident #19) of 5 residents sampled for review of influenza and pneumococcal vaccination. The findings include: On 1/15/25 at 11:48 AM 5 residents' (Residents #13, #43, #18, #19, #14) electronic medical records were reviewed for influenza and pneumococcal immunizations. There was no evidence that Resident #19 was offered, received, or refused the influenza and/or pneumococcal vaccine. On 1/17/25 at 9:06 AM the Director of Nursing (DON) was asked to provided evidence of Resident #19's being offered and/or receiving the influenza and/or pneumococcal vaccine. On 1/17/25 at 11:57 AM the DON provided documentation that Resident #19 had received an influenza vaccine on 9/19/24, however did not provide the survey team with any evidence of Resident #19's pneumococcal vaccine. During the interview the DON stated that any immunization documentation that was not provided, we do not have, and confirmed there was no documentation for Resident #19's pneumococcal vaccine. On 1/17/25 at 12:43 PM the surveyor reviewed the facility's policy, Immunization of Residents which revealed, Policy: Long Term Care residents have much higher risk for complications with pneumonia, COVID 19, and flu illness, so vaccination provides a measure to help achieve the highest level of functioning. On 1/17/25 at 2:20 PM In an interview with the DON she stated that Resident #19 was not offered the pneumococcal vaccine.

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	215351	A. Building B. Wing	01/21/2025

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 49304 Based on record review, staff interview, and policy review, it was determined that the facility failed to provide education to residents regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine and the opportunity to accept or refuse a COVID-19 vaccine. This was evident for 1 (Resident #13) of 5 residents sampled for review of COVID-19 immunizations during the recertification/complaint. The findings include: On 1/15/25 at 11:48 AM 5 residents' (Residents #13, #43, #18, #19, #14) electronic medical records were reviewed for COVID-19 immunizations. There was no evidence that Resident #13 had been offered and/or educated about the risk and benefits and potential side effects of the COVID 19 vaccination. On 1/17/25 at 9:06 AM the Director of Nursing (DON) was asked to provided evidence of Resident #13 had been offered and/or educated about the risk and benefits and potential side effects of the COVID 19 vaccination. On 1/17/25 at 11:57 AM the DON was unable to provide any of the requested documentation for Resident #13. During the interview the DON stated that any immunization documentation that was not provided, we do not have, and confirmed there was no documentation to support facility staff had offered and provided education about the COVID-19 vaccine's benefits, risks, and side effects to Resident #13. On 1/17/25 at 12:45 PM when asked the facility's expectation regarding resident immunizations she stated we offer and if they want it we give it to them. Alert and oriented residents say yay or nay and those with Power of Attorneys, we would contact them to get the consent from them. If a resident refuses, it is documented on the consent form. On 1/17/25 at 12:43 PM the surveyor reviewed the facility's policy, Immunization of Residents which revealed, Policy: Long Term Care residents have much higher risk for complications with pneumonia, COVID 19, and flu illness, so vaccination provides a measure to help achieve the highest level of functioning. On 1/17/25 at 2:20 PM in an interview with the DON she stated that Resident #13 was not educated on or offered the COVID 19 vaccine.