STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215357	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Nursing & Rehab Ctr - Elkridge	7615 Washington Boulevard Elkridge, MD 21075

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. 42886 Based on medical record review and interview, the facility staff failed to thoroughly investigate a complaint of missing personal items (Resident #6). This was evident for 1 out of 12 residents reviewed during a complaint survey. Findings include: Review of resident #6's complaint (MD 00214419) on 4/25/25 at 11:52 am revealed the resident's family made an allegation that the resident's personal items (an adult puzzle and a electronic sound amplifier device) are missing. The surveyor reviewed the resident #6's medical record on 4/25/25 at 12:05pm. The review revealed the resident's records had no evidence of an inventory sheet that listed the puzzle or electronic sound amplifer device. Interview with the Director of Nursing (DON) on 4/25/25 at 1:00pm revealed a grievance/complaint that the complainant reported that a search of the resident #6's room revealed several missing personal items: a puzzle and a electronic sound amplifier device. The surveyor stated that there was no evidence that the facility investigated the complaint. The DON confirmed that the investigation was not done and agreed that the resident would be reimbursed for the missing items.

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
	215357	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Nursing & Rehab Ctr - Elkridge	7615 Washington Boulevard Elkridge, MD 21075

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. 42886 Based on medical record review and interview, the facility failed to accurately document medical information in a resident's medical record (Resident #7). This was evident for 1 out of 12 residents reviewed during a compliant survey. The findings include: Review of complaint MD00214151 on 4/25/25 at 3:00pm revealed resident #7's family complained that the facility failed to provide ADL care for the resident during his/her stay causing the resident to develop a preventable wound. Review of resident #7's medical records on 4/25/25 at 3:15pm revealed the facility nursing staff failed to document ADL care on 1/15/25 (day shift), 1/20/25 (evening shift) and 1/23/25 (night shift). During an interview with the Director of Nursing (DON) on 4/25/25 at 3:40pm, the DON confirmed that facility nursing staff failed to document ADL care for resident #7 on 1/15/25, 1/20/25, and 1/23/25.