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	02/12/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, it was determined that the facility failed to maintain residents' dignity while dining as evidenced by 1) not serving meals at the same time to residents sitting together and 2) facility staff standing while assisting residents with feeding. This was found to be evident in 1) 6 of 10 residents observed while dining and 2) 2 (Residents #21 and #64) of 2 residents observed with feeding assistance.The findings include:1) On 2/6/2026 at 12:29 PM, during lunch service in the common dining room, 8 residents were observed sitting together at a table and 2 residents were observed sitting together at another table. 3 of the residents at the table of 8 residents were observed having meals in front of them. 1 resident at the table of 2 residents was observed having a meal in front of them. At 12:35 PM, the other resident at the table of 2 residents received their meal, 6 minutes after the other resident was observed eating. At 12:43 PM, it was observed that not all residents at the table of 8 residents had received their meals.On 2/6/2026 at 12:44 PM Geriatric Nursing Assistant (GNA) #8 was questioned why all residents sitting together had not received meals at the same time. GNA #8 stated that there was not a specific dining room food cart sent from the kitchen for residents who took their meals in the dining room. They stated that food carts from the kitchen were sent up to the floor and scheduled based on a resident's room number. If the resident was eating in the dining room but had a room number that received a later scheduled food cart, they would be getting their food later than residents with a room number that had an earlier cart delivery. On 2/6/2026, the last resident to be served a meal at the table of 8 residents was observed receiving their food at 12:52 PM, 23 minutes after the first 3 residents at the table were observed with meals.2) On 2/6/2026 at 12:47 PM, during lunch service in the dining room, Licensed Practical Nurse (LPN) #6 was observed standing while feeding Resident #64. LPN #6 was then observed to turn to Resident #21 while standing and picking up a cup and assisting the resident with drinking.On 2/6/2026 at 3:23 PM, surveyor addressed concerns with the Director of Nursing and Nursing Home Administrator.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on administrative record review and staff interviews, it was determined that facility staff failed to ensure that newly hired geriatric nursing assistants (GNA) have the knowledge necessary to provide resident care. This deficient practice was evident for 5 of 5 GNA training files reviewed during the annual survey.The findings include:On 02/10/2026 at 10:45AM, the surveyor requested to review five GNA employee files. Upon review, the surveyor identified that the recently hired employee GNA #16 file were missing the required training in resident abuse, neglect, exploitation, Quality Assurance and Performance Improvement (QAPI), infection control, compliance and ethics, and dementia.During an interview on 02/10/2026, the Director of Nursing (DON) stated that newly hired GNA's complete two days of office orientation followed by two to three days of training on the nursing unit. The surveyor informed the DON of the missing training documents for GNA #16. The DON acknowledged the missing documents and stated she would continue searching for the GNAs training documents.On 02/10/2026 at 2:43 PM, the DON informed the surveyor that she could not find the required training for GNA #16.During an interview with Human Resource (HR) Director on 02/12/2026 at 7:21 AM, he stated he was recently transferred to Lorien Elkridge in December 2025 and assists with the new hire onboarding process. He explained that newly hired GNA's complete two days of in-office orientation, which includes training modules on a platform called Health Academy. The remainder of the training is conducted on the nursing unit.On 02/12/2026 at 9:12 AM, the surveyor request to review training documents for GNA #26, GNA #27, GNA #29, GNA #30, GNA #31 who were hired between October 2025 and January 2026. Review of the training documents revealed the following:GNA #26-No evidence of infection control and compliance and ethics training.GNA #27-No evidence of QAPI, infection control, compliance and ethics, and dementia training.GNA #29-No evidence of QAPI and compliance and ethics training.GNA #30-No evidence of QAPI, infection control, and compliance and ethics training.GNA #31-No evidence of QAPI, infection control, compliance and ethics, and dementia training.According to the facility's assessment staff orientation training includes abuse, neglect, exploitation, dementia, and infection control.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on administrative record review and staff interview, it was determined that the facility failed to ensure staff received Quality Assurance and Performance Improvement Training (QAPI) for new and existing staff. This deficient practice was evident for 6 of 10 employee files reviewed during the annual survey.The findings include:On 02/10/2026 at 10:45 AM, a review of Geriatric Nursing Assistant (GNA) #17, GNA #15, and GNA #25 employee file revealed that QAPI training was complete. Further review for GNA #14 and GNA #16 employee file failed to show evidence of QAPI training.During an interview with the Director of Nursing (DON) on 02/10/2026, she explained that newly hired GNA's complete two days in office onboarding orientation, followed by two to three days of training on nursing unit. The surveyor informed the DON that education was missing from GNA #14 and GNA #16 employee file and requested to review the training files.On 02/10/2026 at 2:43 PM, the DON informed the surveyor that the facility failed to maintain documentation of QAPI training for GNA #14 and GNA #16. In addition, the DON explained that the facility experienced staffing changes in 2025. She stated that the employee previously responsible for staff training is no longer employed at the facility.On 02/12/2026, the surveyor requested to review the training files for GNA #26, GNA #27, GNA #29, GNA #30, and GNA #31. Review of the training file revealed that all GNA's except for GNA #26, were missing documentation of QAPI training from the employee training file.The surveyor informed the Administrator of the findings on 02/12/2026.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on administrative record review and staff interview, it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) received the required annual in-service training. This deficient practice was evident for 4 of 4 GNA employee files reviewed during the annual survey.The findings include:On 02/10/2026 at 10:45 AM, a review of GNA#17, GNA #15, GNA #14, and GNA #25 employee files failed to reveal evidence of annual in-service training. On 02/10/2026 during an interview, the Director of Nursing (DON) stated that the Assistant Director of Nursing (ADON) is responsible for conducting the annual GNA in-service training, however, the ADON was not available for an interview at the time of the annual survey. She further explained that GNA in-service training should be conducted annually. The surveyor informed the DON that annual in-service training documents were missing for four GNA's and requested evidence of completed in-service training for 2025.On 02/10/2026 at 2:43 PM, the DON informed the surveyor that facility failed to maintain documentation of annual in-service training for GNAs in 2025.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to notify residents and representatives of transfers or discharges in writing. This was evident in 2 (Resident #1 and #5) out of 2 residents reviewed for hospitalization. The findings include: On 2/05/2026 at 12:37 PM, a review of Resident #1 and #5's records were conducted. Resident #5 was transferred to the hospital on 1/11/2026 according to progress notes. Resident #1 was transferred to the hospital on [DATE] according to progress notes. On 2/09/2026 at 8:55 AM, further review of Resident #1 and #5 records were conducted. Both residents' transfer notes indicate the residents' representatives are being notified of their transfers via phone call. No evidence of a written notification of transfer was found in Resident #1 or #5's medical record. On 2/09/2026 at 11:39 AM, an interview with the Director of Nursing (DON) was conducted. When asked if the facility has a process in place to notify the resident or representative in writing of a transfer or discharge. The DON stated that the facility currently only notifies representatives of transfers or discharges via Phone call. This surveyor made the DON aware of the requirement to provide residents and representatives with written notification of transfers and discharges.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility failed to perform appropriate revision to care plan goals and interventions as resident care needs became apparent or changed over time. This was found to be evident in 1 (Resident #33) of 35 residents reviewed during the investigation phase of the survey.The findings include:A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care.Resident #33's electronic medical record was reviewed on [DATE] at 1:54 PM. Resident #33 had an active order that was placed on [DATE] that read NO CPR (Cardiopulmonary Resuscitation) OPTION A-2, DO NOT INTUBATE (DNI). Review of Resident 33's current care plan focus of CODE STATUS: I want my resuscitation status to be ATTEMPT CPR (including any and all medical efforts that are indicated during arrest) had not been updated to reflect current resuscitation wishes of the resident and had been initiated on [DATE] with no revision noted.On [DATE] at 3:02 PM, care plan concern was addressed with the Director of Nursing (DON). The DON stated the care plan should have been revised to reflect Resident #33's current CPR status.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide and document individualized activities in accordance with the resident's assessed preferences for 1 of 1 resident (Resident #9) reviewed for activities.The Findings include:On 02/05/2026 at 10:37 AM, a telephone interview was conducted with Resident #9's relative. The relative informed the surveyor that Resident #9 is not involved in any activities.On 02/05/2026 at 1:47 PM, Surveyor visited Resident #9's room, she was seen in bed and there was no music on or any activity going on with the resident.On 02/06/2026 at 12:45 PM, a clinical record review was conducted of Resident #9's most current Minimum Data Set (MDS) and associated Care Area Assessments (CAAs), dated 11/20/2025. Sections C (Cognitive Patterns), F (Preferences for Customary Routine and Activities), and GG (Functional Abilities and Goals) were reviewed to determine cognitive and functional status relevant to activity participation.On 02/09/2026 at 7:29 AM, a follow-up observation was conducted in Resident #9's room. The resident was observed in bed. No music was playing at that time.On 02/09/2026 at 8:20 AM, review of Resident #9's MDS Section F (Preferences for Customary Routine and Activities), dated 09/18/2025, revealed the resident responded, very important to the question, How important is it to you to listen to music you like? The resident also responded, very important to the question, How important is it to you to participate in religious services or practices?On 02/09/2026 at 8:43 AM, an interview was conducted with the Activities Director (Staff #5). When asked about Resident #9's activity program, Staff #5 stated the resident received room visits because the resident did not come out of the room. Staff #5 stated she offered the resident the Daily Chronicle and asked whether he/she wanted to attend activities. Staff #5 further stated that staff would make him/her comfortable in bed, play continuous music, and perform nail care.On 02/09/2026 at 8:52 AM, Staff #5 was asked how frequently Resident #9 received music. She stated the resident was supposed to listen to music three or more times per week. When asked about religious activities, Staff #5 stated religious activities were provided at bedside. When asked to provide documentation or an activity log reflecting the provision of music and religious activities to Resident #9, Staff #5 stated there was no documentation or activity log available. When asked how activities were tracked for residents in the facility, Staff #5 stated there was currently no documentation system in place to track activity provision. When asked whether documentation or an activity log should have been maintained, Staff #5 stated that there should have been documentation.On 02/09/2026 at 9:35 AM, the concern regarding the lack of documentation of individualized activities for Resident #9 was discussed with the Nursing Home Administrator (NHA). The NHA acknowledged the absence of documentation and activity tracking as a concern.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, clinical record review, and interview, it was determined that the facility failed to ensure that enteral nutrition (tube feeding) and hydration canisters were labeled and dated to ensure safety and sanitation. This deficient practice was evident for 1 (Resident #7) out of 1 resident reviewed for tube feedings.Findings include:Enteral tube feeding (tube feeding) is a method of delivering nutritionally complete liquid formula directly into the stomach or small intestine via a tube. It is used when a person cannot eat enough by mouth to meet their nutritional needs but has a functioning gastrointestinal tract.mL/hr (milliliters per hour) in enteral feeding defines the speed at which liquid formula is delivered through a feeding tube over one hour, usually regulated by a pump. It determines the flow rate needed to deliver a specific total volume of nutrition (dose) over a set time or period. On 02/05/2026 at 12:47 PM, an initial observation of Resident #7's room was conducted. The resident was observed receiving a tube feeding infusion at a rate of 60 mL/hr. The tube feeding container and the attached tubing were not labeled with the resident's name, the date, or the start time. A manufacturer's label was present on the container for this purpose but remained blank. Additionally, the water canister used for flushes was not labeled or dated.On 02/05/2026 at 2:58 PM, a clinical record review for Resident #7 was conducted. The record identified that the resident received nutritional support via a feeding tube with Nothing by Mouth (NPO) status. Physician orders indicated: Diabetasource AC via feeding pump at 60 mL/hr for 20 hours per day (10:00 AM to 6:00 AM). Total nutrient 1200 mL. Orders also specified water flushes of 240 mL every 4 hours for hydration.On 02/09/2026 at 12:44 PM, a follow-up observation of Resident #7's room revealed the tube feeding was running at 60 mL/hr. The feeding container, tubing, and water flush canister remained unlabeled and undated. A syringe for water flushes was not observed at the bedside.On 02/10/2026 at 12:41 PM, a third observation of Resident #7's room was conducted. The tube feeding continued to run at 60 mL/hr. The feed and water canisters remained without identifying information (name, date, or start time). A syringe for flushes was not observed in the resident's room.On 02/10/2026 at 12:46 PM, an interview was conducted with Licensed Practical Nurse (LPN) Staff #6 regarding the expectation for dating tube feedings. LPN #6 stated that the feed and water flushes are required to be labeled and dated with the resident's name and the time it was initiated. LPN #6 confirmed that Resident #7's current feeding setup lacked this information and stated she would label and date it immediately.On 02/10/2026 at 1:55 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that enteral containers should be labeled with the date and the shift they are changed. She further stated that a syringe for flushing the tube should be maintained at the patient's side and changed with every feeding.On 02/10/2026 at 1:59 PM, the observations and lack of labeling were discussed with the DON. The DON acknowledged the concern and identified it as a problem.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, it was determined that the facility failed to maintain a medical record in the most accurate form. The was found to be evident for 1 (Resident #33) of 35 residents reviewed during the investigation phase of the survey.The findings include:MOLST (Medical Orders for Life-Sustaining Treatment) is a medical order form that translates a patient's preferences for end-of-life care into actionable instructions for healthcare providers. Unlike a living will or healthcare proxy, which are legal documents for future use, a MOLST form consists of actual medical orders that must be followed immediately by all health professionals, including emergency medical services (EMS).A hard chart (or paper chart) is the physical, tangible medical record for a resident. Resident #33's electronic medical record (EHR) was reviewed on [DATE] at 1:54 PM. Resident #33 had an active order that was placed on [DATE] that read, NO CPR (Cardiopulmonary Resuscitation) OPTION A-2, DO NOT INTUBATE (DNI). A social work progress note dated [DATE] at 2:43 PM in Resident #33's EHR stated, Resident has MOLST code status of NO CPR A2. Another social work progress note dated [DATE] at 1:55 PM stated, The Resident has a MOLST on file indication NO CPR/DNI. 2 copies of voided MOLSTS were uploaded into Resident #33's EHR, no active MOLST was identified in the EHR.On [DATE] at 2:30 PM, Resident #33's hard chart was reviewed and disclosed a MOLST form dated [DATE] that attempt CPR was selected under CPR (Resuscitation) Status.Geriatric Nursing Assistant (GNA) #8 was interviewed on [DATE] at 2:35 PM and stated that copies of residents' up-to-date MOLST forms are kept in their hard charts.On [DATE] at 3:02 PM, the Director of Nursing (DON) and Social Services Director (SSD) were interviewed and made aware of the concern that Resident #33's MOLST information in their EHR and MOLST form in their hard chart did not match. The DON stated that they would figure out what happened and make sure to correct any discrepancies.On [DATE] at 11:05 AM, Resident 33's hard chart was reviewed and an updated MOLST form dated [DATE] was observed filled out by the facility's Medical Director.On [DATE] at 12:51 PM, the DON was interviewed and stated they did not know why Resident #33 did not have an updated MOLST form in their hard chart to match information in their EHR. The DON stated that the issue had been corrected with an updated MOLST form.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on administrative record review and staff interview, it was determined that the facility failed to ensure staff received training on abuse, neglect, and exploitation training. This deficient practice was evident for 1 of 5 employee files reviewed during the annual survey.The findings include:On 02/10/2026 at 10:45 AM, a review of Geriatric Nursing Assistant (GNA) #16s employee file revealed a hired date of October 2025. Further review failed to show evidence of abuse training.During an interview with the Director of Nursing (DON) on 02/10/2026, she explained that newly hired GNA's complete two days in office orientation, followed by two to three days of training on nursing unit. The surveyor informed the DON that education was missing from GNA #16s employee file and request to review the training files.On 02/10/2026 at 2:43 PM, the DON informed the surveyor that the facility failed to maintain documentation of abuse training for GNA #16.On 02/11/2026 the Administrator was made aware of the finding.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on administrative record review and staff interview, it was determined that the facility failed to ensure staff received required compliance and ethics training. This deficient practice was evident for 3 of 5 employee files reviewed during the annual survey.The findings include:On 02/10/2026 at 10:45 AM, a review of Geriatric Nursing Assistant (GNA) #17's employee file revealed a hired date of March 2024. Further review of the file failed to show evidence of compliance and ethics training completed in 2025. The surveyor reviewed four additional employees files and identified that compliance and ethics training was missing for GNA # 14 and GNA #16.During an interview with the Director of Nursing (DON) on 02/10/2026, the surveyor informed the DON that documentation of 2025 compliance and ethics training was missing from three GNA employee files. The surveyor again requested evidence of completed compliance and ethics training for the three GNAs. On 02/10/2026 at 2:43 PM, the DON informed the surveyor that the facility failed to maintain documentation of compliance and ethics training for GNA #17, GNA #14 and GNA #16.