

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Lorien Bulle Rock		STREET ADDRESS, CITY, STATE, ZIP CODE  1501 Blenheim Farm Lane Havre DE Grace, MD 21078	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility reported incident details, resident medical records, facility staff personnel files, and interview with facility staff, it was determined that the facility failed to ensure a resident was free from abuse. This was evident for 1 (Resident #76) out of 35 residents reviewed during the annual survey.</p> <p>The findings include:</p> <p>The Office of Health Care Quality received a facility reported incident on 3/22/23, MD00190490, that alleged a facility staff, Registered Nurse, RN #12, verbally abused Resident #76 on 3/20/23 during the 3 pm to 11 pm shift. In the investigation, the facility substantiated through multiple witnesses (Staff # 13, GNA #14, Staff #15, and GNA #16) that RN #12 used verbally abusive and inappropriate language while rendering care to Resident #76.</p> <p>Resident #76 was admitted to the facility on [DATE] for long term care services. At the time of the incident, Resident #76 was under hospice care with diagnoses including, Alzheimer's, Dementia, and Repeated Falls. Review of Resident #76's MDS assessment dated [DATE] showed the resident was dependent for all care, transfers with a mechanical lift, and his/her BIMS was 1/15.</p> <p>A review of the facility investigation file showed:</p> <p>Resident #76 does attempt to get out of bed on his/her own and requires frequent monitoring from staff to keep him/her safe. On the evening shift of 3/20/23, Resident #76 was brought into the hallway in a recliner to offer a change in environment and allow staff to monitor him/her more closely. The Resident was repeatedly attempting to climb out of her chair, putting himself/herself in danger of falling which required constant supervision and interaction with staff. Staff later reported that the assigned Nurse, RN #12, showed visible signs of stress secondary to the needs of the residents that were in her assignment. Staff report that RN #12 made comments loud enough to be heard by anyone in the area that were degrading .</p> <p>On 6/25/25 at 12:25 PM further review of the investigation file revealed a handwritten statement by Housekeeping Staff #13 that reported that RN #12 was yelling at Resident #76 and grabbing his/her pant leg, pulling his/her leg violently and RN #12 said in front of the resident, If I could open the stairwell door, I would push the resident in there.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The file also revealed that another facility staff member, geriatric nursing assistant, GNA #14, wrote a statement that he/she witnessed RN #12 being verbally harsh to Resident #76 on 3/20/23 during the 3pm to 11pm shift.</p> <p>Statements from a Dietary Aide, Staff #15, revealed that he/she saw RN #12 pushing a Resident into a chair and telling him/her to sit down, then stating you know what, get up and fall down, I don't care and then walked away.</p> <p>An additional statement was reviewed which noted that GNA #16 wrote a statement that he/she saw with his/her own eyes on 3/20/23 RN #12 threaten to push Resident #76 down the back steps.</p> <p>Review of a documented interview held on 3/24/23 between the Director of Nursing (DON) and RN #12 showed that: RN #12 reported that this Resident (Resident #76) and one other were restless that evening and he/she did not respond appropriately. RN #12 stated that he/she had an Emotional breakdown and realized he/she needed to remove himself/herself from the unit. He/She reports that he/she used inappropriate language stating that I have to get the he!! out and that he/she can't stand this damn s*!t. He/She reports that her words were not directed towards anyone, it was just his/her response to the situation.</p> <p>On 6/25/25 at 1:09 PM the surveyor reviewed the facility's Abuse Prevention Policy which defined verbal abuse as: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents {or their families}, or within their hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident</p> <p>On 6/25/25 at 1:18 PM a review of RN #12's personnel file, revealed a front page that stated Do not rehire, he/she would have been terminated for verbal abuse. Term date 4/1/23, last day worked 3/20/23. The surveyor reviewed this information with the DON who confirmed the findings in RN #12's personnel file.</p> <p>On 6/26/25 at 7:30 AM the surveyors held an interview with the DON. The surveyors reviewed the staff's witness statements and UM #12's statement with the DON. The DON confirmed that the allegation of verbal abuse was substantiated and even though UM #12 did not return to work since 3/20/23, the decision had been made to terminate UM #12's employment due to these findings.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interviews and record review, it was determined that the facility failed to immediately report an allegation of abuse to the State Office of Health Care Quality within the allotted two-hour timeframe. This was found evident in 2 out of 4 (Resident #74 &amp; 81) residents reviewed for abuse allegations during an annual and complaint survey. The findings include:</p> <p>1a) On 6/30/25 at 9:15 AM, the surveyor reviewed the facility investigation into an allegation of abuse related to Resident #81. The investigation revealed that an allegation of abuse was reported to a staff member by Resident #81's family member on 4/12/25 in the afternoon, however, the date the allegation was reported to the Office of Health Care Quality (OHCQ) and the date the investigation was started was 4/13/25. On further review, a progress note written on 4/12/25 at 3:07 PM, by Licensed Practical Nurse (LPN) #10, stated that Resident #81's daughter reported that Resident #81 told her that someone working the night shift had been hurting him/her. On 6/3/25 at 10:58 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA confirmed that the allegation was not reported to the OHCQ immediately (two hours after the allegation) and that the reason why the allegation was not reported or the investigation started, was due to the staff not notifying him until the following day. 1b) On 06/25/25 at 11:20 am a review of the facility's investigation related to Resident #74 revealed Maintenance Tech #19 statement indicated the resident told them about the alleged incident on 10/11/22 10:30 am. EVS Director #18 reported on 10/11/22 at 2:30 PM that the resident reported being smacked by someone during the early hours on the 11 PM - 7 AM shift. At 12:02 PM further review of the investigation revealed the incident was reported to the state agency at 4:30 PM which was outside of the 2-hour allotted timeframe to report an allegation of abuse. On 06/25/25 at 2:02 PM during an interview with the Director of Nursing (DON) the surveyor asked what the expectation of the staff related to reporting allegations of abuse. The DON verbalized that the staff should report abuse immediately to the DON or Administrator. They are aware of the 2-hour window and there was no reason for the delay. They typically report allegations of abuse within 2 hours.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review and interviews it was determined that the facility staff failed to interview all the staff who worked on the unit during the investigative phase of an allegation of abuse. This deficient practice was evidenced in 1 (#74) of 10 facility reported incident investigation reviewed during the recertification and complaint survey.</p> <p>The findings include:</p> <p>On 6/25/25 at 11:20 AM a review of the facility's investigation of Resident #74 allegation of abuse, the surveyor noted all the staff who worked on the unit during the alleged incident, statements were not included in the investigation.</p> <p>On 6/26/25 at 2:02 PM during an interview with the Director of Nursing (DON) the surveyor asked what process they follow when completing an investigation. The surveyor asked if there were statements from two Geriatric Nursing Assistant's (GNA) and a nurse who also worked on the unit during the time of the alleged incident. The DON verbalized they are in the process of revamping the policy on how investigations will be done. There were only 2 GNA's working at that time. The other GNA came in at 3 AM. Usually they interview everyone who worked. Not sure why the interviews are not part of the investigation because they always do that.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on record review and staff interview it was determined that the facility failed to reposition the resident, toilet or check the resident for being wet or being soiled for 4.5 hours. This was evident for 1 (Resident #80) of 1 residents reviewed for ADL's during an annual and complaint survey</p> <p>Findings include:</p> <p>On June 30, 2025 at 9:45 AM during a chart review, it was noted that the Physical Therapist/Occupational Therapist had documented that after therapy on 3/25/2025, the resident was returned to his/her room at 11:00 AM and instructed to sit in the chair for 1 hour. The resident was given the call bell and told to alert the staff when he/she was ready to go back to bed.</p> <p>The surveyor reviewed a complainant that stated that Resident #80's daughter called at 3:15 PM stating that he/she was left in the wheelchair since early that morning and that no one had responded to his/her call bell.</p> <p>At 9:15 AM on July 1, 2025, a further chart review noted that on 3/25/2025 at 3:41 PM, Registered Nurse (RN) #20 received a call from the resident's daughter stating his/her parent had been in the chair since 11 AM and needed to be put to bed. The nurse reported that the resident stated he/she had been in the chair for 6 hours.</p> <p>On July 1, 2025 at 9:49 AM the Director of Nursing (DON) was interviewed and stated that according to the documentation the resident was put back to bed at 3:21 PM on 3/25/2025. There was no documentation for the resident being re-positioned, toileted or checked for being wet or soiled.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 1c) On 7/01/25 at 8:45 AM a review of Resident #225 printed medical record revealed there was no documentation to verify the resident was repositioned at least every two hours. In addition, the staff documented the type of assistance the resident needed to get dressed but the documentation did not specify whether the resident was dressed.</p> <p>On 7/01/25 at 9:45 AM during an interview with the Director of Nursing (DON), the surveyor verbalized there was no documentation to verify the resident was being turned and/or repositioned. The DON verbalized they recently started having the GNA's sign off in Tasks. The staff should make sure the residents are turned every 2 hours.</p> <p>Based on interviews, and record review, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by keeping complete and accurate documentation. This was found evident in 3 (Resident #62, #28 &amp; #225) out of 35 residents reviewed during the survey.</p> <p>The findings include:</p> <p>1a) On 6/24/25 at 9:06 AM, the surveyor conducted an interview with Resident #62. During the interview Resident #62 stated that he/she had struggled with constipation at times but was also offered medications to help.</p> <p>On 6/25/25 at 11:58 AM, the surveyor reviewed Resident #62's medical record. The review revealed that the TASK documentation had an area to document Bowel Movement (BM) size and consistency as well as control as in continent/incontinent. The surveyor reviewed the June 2025 documentation for size and consistency and noted Resident #62 was documented as having no bowel movement from 6/9/25-6/17/25, (9 days). On review of the control of bowel movement for June 2025 Resident #62 was documented as having no bowel movement from 6/9/25-6/13/25 (5 days).</p> <p>On further review the surveyor noted a progress note written on 6/12/25 by Nurse Practitioner (NP) #11 that stated Resident #62 reported that he/she had to strain to have bowel movements. The note further addressed the concern with a medication adjustment.</p> <p>On 6/26/25 at 7:40 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor relayed the concern about prolonged days of no bowel movement for Resident #62. The DON stated he believed the documentation was inaccurate and that he would follow-up.</p> <p>The surveyor conducted a follow-up interview with the DON. During the interview the DON provided the surveyor with a routine skilled note dated 6/13/25 in which Resident #62's Date of Last BM was documented as 6/11/25. He further stated he agreed that there were inconsistencies and inaccuracies in the documentation and that the facility started re-education in regards to documenting expectations.</p> <p>1b) On 6/25/25 at 8:55 AM, the surveyor reviewed Resident #28's medical record. The record reviewed documentation that a wander bracelet was on Resident #28's left ankle.</p> <p>(continued on next page)</p>		

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F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>On 6/27/25 at 10:47 AM, the surveyor reviewed Resident #28 Minimum Data Set (MDS) assessments. On the assessment dated [DATE] and 4/15/25 Resident #28 was documented as having no wandering behaviors in section E.</p> <p>Next the surveyor reviewed resident #28's care plan. A care plan was initiated on 3/10/25 that stated Resident #28 is at risk for elopement related to exit seeking behaviors.</p> <p>On 6/27/25 at 9:39 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked the DON why a care plan was initiated for elopement when there was not documentation in the medical record to indicate Resident #28 had exit seeking behaviors. The DON stated he would look into it and follow-up. He further stated he was not sure why the behaviors were not coded in the MDS assessment.</p> <p>On 6/27/25 at 10:12 AM, the surveyor conducted a follow-up interview with the DON and Minimum Data Set Coordinator Staff #5. The DON stated that he spoke to the unit manager and the day the care plan was created the unit manager observed the resident in the hallway by the door, and that the Resident stated that he/she was going to go home. He confirmed that there was no documentation in the medical record of this incident. Staff #5 confirmed that the elopement/wandering was not coded in the MDS assessment because the behavior was not documented in the medical record. The DON confirmed that this behavior should have been documented in the medical record.</p>		