STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE 300 International Circle Cockeysville, MD 21030	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on medical record review and interview with facility staff, it was determined that the facility staff failed to enhance a resident's dignity. This was evident during the review of a facility reported incident regarding activities of daily living care 2 of 30 (#6, R4). This failure placed residents at risk of their rights being violated and not upheld. The findings include: 1.) Review of the facility reported incident (FRI) on 10/17/24 at 11:55 AM regarding Resident #6 and an allegation of verbal abuse revealed that residents' family member reported to the (previous) facility Director of Nursing (DON) # 18 staff were rude when delivering residents breakfast trays. The concern was further clarified that staff would leave the breakfast trays in front of the resident and then would not assist the resident right away with eating. Record review at 12:30 PM on 10/17/24 revealed that Resident #6 was dependent on staff for meals and eating as noted in his/her care plan and in the daily nursing progress notes. Per the resident's care plan s/he was also noted to have poor intake and a 'poor feeder.' The DON was interviewed on 10/17/25 at approximately 12:50 PM. The expectation would be for staff to feed residents when the tray is delivered. The concern that family reported that staff were just leaving the breakfast meal tray in front of Resident #6 for an unknown amount of time prior to aiding the residents was reviewed with the current facility DON and Administrator. cross reference F609, F610, F835 2.) Review of the facility's policy titled, Resident [NAME] of Rights undated reads in part, .A. The facility shall provide care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, promote and respect the rights of the residents and in full recognition of the resident's individuality . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Masonic Homes Ltd	300 International Circle Cockeysville, MD 21030

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's undated Admission Record, located in the resident's electronic medical record (EMR) under the Resident Summary tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Surgical Aftercare following surgery on circular system, Hypertensive Heart and Chronic Kidney Disease and Pneumonia. Review of R4's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/08/24 located in the resident's EMR under the MDS tab revealed the facility assessed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively alert. Review of facility Concern Form, receive date 07/18/24 revealed R4 reported s/he had a rough time during the shower. R4 stated the nursing aide asked him/her to stand and told him/her if s/he did not stand, she would let him/her fall. R4 also stated s/he was thrown against the wall and feet stepped on. Review of R4's typed statement dated 07/18/24 documented R4 stated, Certain staff should be fired, they threw me in the shower, pushed me against the wall and stepped on my feet. I begged them to stop, they said, they would let me fall. Interview with Geriatric Nursing Assistant (GNA) 17 on 10/17/24 at 2:44 PM, GNA 17 stated she gave R4 a shower and had assistance from GNA 18. GNA 17 stated R4 expressed they did not want a shower, but their family member requested the shower. GNA 17 stated R4 was screaming out and attempting to slide out of the shower chair once they were in the shower. GNA 17 stated s/he did not want to continue with the shower, but GNA 18 insisted since the family requested. Interview attempted with Geriatric Nursing Assistant (GNA) 18 on 10/22/24 at 11:31 AM via phone call and no answer. During an interview on 10/18/24 at 09:06 AM, Director of Nursing (DON) stated they expect resident's rights to be upheld. DON stated the GNA staff were trained to report to the nursed if a resident refuses care. DON stated the nurse is then supposed to follow up and try to get the resident to receive care. GNA stated that if the resident still does not want care following the nurse intervention, then staff are to document and try at a later time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER: Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 International Circle Cockeysville, MD 21030	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30428 Based on review of facility documentation and interview with staff it was determine the facility staff failed to ensure that allegations involving abuse were reported to the Administrator of the facility and the State Agency no later than 2 hours after the allegation was made and results of all investigations were reported within 5 working days. This was evident in 3 of 26 (#6, #2 and #10) facility reported incidents reviewed during a complaint survey. The findings include: 1. Review of the facility reported incident (FRI) regarding Resident #6 and an allegation of verbal abuse on 10/17/24 at 11:55 AM revealed that residents' family member reported to the (previous) facility Director of Nursing (DON) #18 on 6/14/24 that staff were rude when delivering residents breakfast trays. The concern was further noted that staff would also leave the breakfast trays in front of the resident and then would not assist the resident right away with eating. On 6/20/24 a care plan meeting was held. That same family member, Resident #6's representative, asked the DON what the follow-up was to his reported concern about verbal abuse. According to the statement in the FRI, the DON did not feel the concern from the family member rose to the level of verbal abuse and no official investigation was initiated. It was not until 6/20/24 that an investigation into the care Resident #6 received on 6/14/24 was addressed, although the family reported concerns about breakfast delivery and staff to resident interactions. The concern that the previous DON failed to identify reported concerns of potential abuse and elevate them to an investigation was reviewed with the current DON and Nursing Home Administrator (NHA) throughout the survey and again during exit on 10/21/24. 2. Review on 10/16/14 at 10:45 AM of the FRI for Resident #2, revealed that on 8/10/24, Resident #2 reported to LPN #20 concerns related to possible abuse from GNA's that had provided him/her with activities of daily living. However, it was not until 8/14/24 that LPN #20 reported this concern to the (previous) DON #18. This concern was completed on a grievance form and the staff were educated on customer service training, not abuse or timely reporting of abuse. These collaborative concerns were reviewed with the current facility administration throughout the survey. 3. Review of the FRI for Resident #10 on 10/18/24 at 10:37 AM revealed on 11/7/23 Resident #10 notified staff that s/he was not being treated well, that a GNA was being 'pushy' and rushing him/her with care. This was immediately reported to the (previous) DON. The results of the concern form completed by the DON stated in actions: 'assignment change for employee, I reassured patient that GNA would be educated on customer service;' (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE 300 International Circle Cockeysville, MD 21030	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/9/23 another concern form was completed. The Social worker reported that the patient had continued concerns reflecting from the previous Tuesday and Wednesday (7th and 8th) as previously reported, that the aide was rough and yelling at him/her. The documented facility follow-up from the previous DON was 'GNA re-educated on customer service and having a team member assist with repositioning, GNA educated and assignment on unit has been changed.' A report was not sent to the Office of Health care Quality until 11/9/23 at 4:22PM by the facility DON. It was documented on the form that she notified the NHA that she was just notified at 2:30 PM on 11/9/23 by the Social worker that Resident #10 had concerns about a GNA being 'pushy' while providing care. The interventions included updating the resident care plan, education to the staff, interviews and changing the employes schedules. The facility report was submitted as mental/verbal abuse. According to the facility report there were 2 GNAs identified of concern. The concern that the DON was actually aware of the incident on 11/7/23 and dismissed it as a 'customer service' issue was reviewed with the current facility DON on 10/18/24 at 12:10 PM. cross reference F610, F835

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Masonic Homes Ltd	300 International Circle Cockeysville, MD 21030

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. 30428 Based on medical record review and interview with facility staff, it was determined that the facility staff failed to thoroughly investigate allegations related to potential abuse and injuries of unknown origin. This was evident during the review of 5 of 30 (#4, #6, #7, #10, #25) incidents requiring facility reports and investigations. The findings include: 1. Review of the FRI regarding Resident #6 and allegation of verbal abuse on 10/17/24 at 11:55 AM revealed that residents' family member reported to the (previous) facility Director of Nursing (DON) # 18 on 6/14/24 that staff were rude when delivering residents breakfast trays. The concern was further noted that staff would leave the breakfast trays in front of the resident and then would not assist the resident right away with eating. Record review at 12:30 PM on 10/17/24 revealed that Resident #6 was dependent on staff for meals and eating as noted in his/her care plan and in the daily nursing progress notes. On 6/20/24 a care plan meeting was held. That same family member, Resident #6's representative, asked the DON what the follow-up was to his reported concern about verbal abuse. According to the statement in the FRI, the DON did not feel the concern from the family member rose to the level of verbal abuse and no official investigation was initiated. It was not until 6/20/24 that an investigation into the care Resident #6 received on 6/14/24 only was addressed, although the family reported concerns about breakfast delivery and staff to resident interactions. The concern that the previous DON failed to identify reported concerns of potential abuse and elevate them to an investigation was reviewed with the current DON and NHA throughout the survey and again during exit on 10/21/24. cross reference F550, F609, F835 2. Review of a facility reported incident (FRI) regarding Resident #7 on 10/18/24 at 12:27 PM revealed a fall which was the 6th in a month and the second requiring hospitalization . This fall was documented as occurring in the common area according to a statement from the on-duty nurse that day who did not observe the fall but documented seeing the resident afterwards on the floor. Resident #7 was sent to the hospital and diagnosed with a compression fracture of the thoracic vertebrae. Review of the facility 5-day follow-up investigation report form noted that there were no staff or resident interviews conducted. Additionally, section 3 ,the conclusion, was noted as 'N/A' under not verified and section 4 for corrective action taken was left blank and further was signed and submitted by staff #18, the previous DON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE 300 International Circle Cockeysville, MD 21030	

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	The concern that there was no conclusion or preventative measures presented was reviewed with the administrative team, that included the DON, Administrator and ADON on 10/18/24 and again during exit on 10/21/24. 3. Review of the FRI for Resident #10 on 10/18/24 at 10:37 AM revealed on 11/7/23 that Resident #10 notified staff that she was not being treated well, that a GNA was being 'pushy' and rushing [him/her] with care. This was immediately reported to the (previous) DON. The results of the concern form completed by the DON stated in actions: assignment change for employee, I reassured patient that GNA would be educated on customer service On 11/9/23 another concern form was completed. The Social worker reported that the resident had continued concerns reflecting from the previous Tuesday and Wednesday (7th and 8th) as previously reported, that the aide was rough and yelling at him/her. The documented facility follow-up from the previous DON was GNA re-educated on customer service and having a team member assist with repositioning, GNA educated and assignment on unit has been changed. A review of the schedules for 11/9/23-12/1/23 revealed only 10 of 26 days where Resident #10 was not in the presence of either identified employee that s/he had concerns and allegations of abuse against from 11/7-12/1/23 The initial allegation was made on 11/7/23. On 11/8/23, 11/9, 11/12, 11/20, 11/21, 11/23, 11/25 and 11/30 one of the 2 GNAs was assigned to Resident #10. On 11/11, 11/22, 11/26, 11/28 and 11/29 one of the 2 GNAs was caring for residents in adjacent rooms. There was no evidence that either GNA was suspended pending investigation, or that there was any preventative action put in place to prevent further occurrences of potential abuse to Resident #10. cross reference F609, F835 37296 4. Review of a facility reported incident MD00183392 on 10/18/24, revealed the facility reported to the Office of Health Care Quality (OHCQ) on 9/13/22, Resident #25 reported injury of unknown origin. On 10/18/24 at 10AM a review of the facility investigation report revealed the facility staff have no record of a completed investigation to include interviews from nursing staff other residents and all the staff on the unit. On 10/18/24 at 10:30 AM the Director of Nursing confirmed that the investigation failed to include interviews with other residents and staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE 300 International Circle Cockeysville, MD 21030	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on medical record review and interview with facility staff, it was determined that the facility staff failed to appropriately review a medication order and administer medication according to professional standards. This was evident for 1 of 3 facility reported incidents reviewed regarding medication management (Resident #1). The findings include: Review of the facility reported incident for Resident #1 on [DATE] at 11:30 AM revealed that Resident #1 was administered 10 x the ordered dose of Morphine. Further review of the incident report revealed that the medication order was taken as a verbal order on [DATE] at approximately 3pm by RN #7. The order was intended for a concentration of 20mg/ml of morphine to administer a dose of .25ml every 2 hours as needed for a dose of 5mg of Morphine. However, RN #7 transcribed the order as 2.5ml. When the medication arrived, the controlled drug receipt/record disposition form showed that the concentration of the Morphine was 20mg/ml. According to the medication administration record (MAR) the order for the Morphine was put in as a concentration of 10mg/5ml, give 2.5ml by mouth every 2 hours as needed for shortness of breath, pain. This morphine order was signed off and given at 10:02 AM and 9:23 PM. The delivery of the Morphine came with a 1 ml syringe for administration. This was confirmed on tour [DATE]. Therefore, staff LPN #6 would need to draw up the Morphine liquid 2.5 times for administration. Although the order on the MAR that was signed off and the provided medication from the pharmacy did not match, the nurse on duty, LPN #6, still administered the medication without question. LPN #6 failed to verify that the delivered medication matched the ordered medication on the MAR, therefore a dose 10x the ordered dose was administered. In a statement in the facility report RN #7 stated that she did transcribe the verbal order incorrectly, however, if the medication had arrived when she was on duty she would have known that it was wrong when she went to administer it by the amount that had to be drawn up that she had never given 2.5 whole syringes of morphine before. Resident #1 subsequently passed away at 1:40 AM on [DATE]. An autopsy was completed and determined that Resident #1 died of Morphine Intoxication. Multiple interviews during the survey with the current facility DON revealed that education is ongoing regarding verbal orders related to narcotics verification. Additionally they review verbal orders in morning meeting with an action plan in place with the unit managers, ADON and DON which began on [DATE] and is currently ongoing. cross reference F760

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE 300 International Circle Cockeysville, MD 21030	

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 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. 37296 Based on clinical record review and staff interviews, it was determined that the facility staff failed to ensure adequate supervision while positioning a resident in bed during the provision of care. This deficient practice resulted in the Resident #17 falling out of bed. This was evident for 1 (17) of 1 resident reviewed for accidents. The findings include: On 10/17/24, a record review was conducted which revealed that Resident #17 had diagnoses which included myalgia, osteoarthritis, pain and quadriplegia. Quadriplegia is paralysis that affects all a person's limbs. The MDS (Minimum Data Set) is a screening tool that is utilized to ensure each resident's individual needs are identified. A review of the MDS assessment, with an assessment reference date of 07/7/2023, identified that to turn from side to side and position body when in bed, the resident was totally dependent on staff for the activity and required 2 staff persons to physically assist. According to facility notes dated 9/29/23 at 12:30 PM, Resident #17 fell from bed during activities of daily living (ADL) care. When the Resident was being turned over in bed, she fell to the floor due to poor trunk control and landed on the floor on her buttocks. The Resident was assessed by RN and no outward injuries noted. The Resident did complain of left hip pain 4/10, on the pain score of 0-10 with 10 as the worst pain. The resident did receive Tylenol for pain management at 6 AM. The Residents declined to go to the hospital and an x-ray was obtained in the facility. The x-ray report dated 9/29/23 indicated a suspected impacted femoral neck fracture (fracture hip). The Resident was transferred to the hospital for evaluation. A facility incident report was obtained. The report described how Staff #19, a Geriatric Nursing Assistant had been providing care. On 10/17/24 at 1:10 PM, GNA's #19 interview revealed that the resident was on an air mattress and when I rolled him/her over to give ADL care the air mattress deflated, and s/he fell out of bed. The bed was at my waist height. The resident landed on his/her knees. The resident's husband was sitting in the room when the incident occurred. GNA #19 stated that he/she was not aware that the resident was a 2 person assist until after the incident. When asked how a GNA would know how much assistance a resident requires, Staff #19's answer included using the Kardex that can be found in the resident's electronic chart. On 10/17/24 at 1:50 PM, an interview was conducted with the Director of Nursing who confirmed that the Resident's Kardex did not include the assistance that Resident #17 needed with ADL care. Before providing care to Resident #17, Staff #19 would have been able to quickly find information pertaining to the resident's bed mobility in the Kardex. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE 300 International Circle Cockeysville, MD 21030	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 1:30 PM, further record reviewed of the acute care discharge summary reveal that the resident did not have a fracture or any injuries from the fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Masonic Homes Ltd	300 International Circle Cockeysville, MD 21030

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42886 Based on medical record review and interview, the facility failed to monitor a resident's weight loss and nutritional status. This was evident for 1 of 30 (resident #30) residents reviewed during a complaint survey. Findings includes: On 3/27/24, the State of Maryland's Office of Health Care Quality received a complaint which alleged the facility failed to monitor resident #30's status and well-being during his/her stay in the facility. Review of resident #30's medical record on 10/17/24 at 8:11 am revealed the resident was ordered to be weighed monthly. The resident's weight on 6/14/22 was 124 lbs. The resident's weight on 7/2/22 was 104 lbs. Review of the nutritional assessment on 8/4/22 revealed the assessment was done after the resident was transferred to a local hospital after a fall on 7/4/22 that caused a laceration to the resident's forehead. The resident's weight had increased to 108.4 lbs. after the hospital stay. The assessment also revealed that the resident was given a PEG tube, a feeding tube that used to provide nutrition to residents that are unable to eat or cannot swallow safely. Continued review of resident #30's medical record on 10/17/24 at 11:30 am revealed that Certified Registered Nurse Practitioner (CRNP) #15 assessed the resident an average of twice a week for the month of June 2022. A review of CRNP #15's reports during this time period revealed no evidence that the resident had any weight loss. CRNP#15's reports for June 2022 stated that the resident had issues with swallowing difficulties and dehydration which were initially treated by encouraging increased oral intake of thickened liquids and eventually the resident was hydrated by IV fluid. There was no evidence that CRNP #15 referred the resident's case to a dietitian for increased nutritional supplementation. The surveyor interviewed CRNP #15 on 10/18/24 at 2:18 pm. CRNP #15 confirmed that he/she provided care to resident #30 in the month of June 2022. CRNP #15 also confirmed that the resident was being treated for several conditions including COVID 19 and a urinary tract infection during the month of June 2022. CRNP #15 stated that facility nursing staff failed to inform him/her of the resident's poor oral intake causing the resident to lose weight. The surveyor informed the administrator and the Director of Nursing (DON) of the deficient practice on 10/21/24 at 11:00 am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER: Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 International Circle Cockeysville, MD 21030	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 30428 Based on medical record review of a facility reported incident and interview with facility staff, it was determined that the facility failed to address residents pain. This was evident for 2 of 5 (#1 and #17) residents reviewed for incidents of injuries with pain. The findings include: 1. Review of the facility reported incident (FRI) on 10/16/24 at 11:30 AM for Resident #1 revealed a noted change in condition identified by the RN on duty staff #5, that was sent to the on-call provider, MD, staff #21. RN #5 reported that Resident was exhibiting signs and symptoms of pain and discomfort, continually removing his/her oxygen and has episodes of agonal breathing .no longer eating or drinking. Is it possible to have an order for Morphine or some type of narcotic pain killer to keep him/her comfortable? This was sent on 8/7/24 at 11:31 AM under urgency -1 hour. At 11:42 AM on 8/7/24, MD staff #21, responded Please reach out to CRNP #7 as she is the first point of contact in E-medical. The concern and change in condition were resent to staff CRNP #7 at 11:49 AM under Urgency-1 hour. There was no response, although the Emedical was escalated 3 times until approximately 3:00 PM when staff CRNP #7 stated to continue with Resident #1's Ativan order. Review of the facility investigation revealed a statement from staff RN #5 that she did receive a verbal order for Morphine around 3pm on 8/7/24 from CRNP #7, however this still was not available and administered to Resident #1 until 8/8/24 at 10:02 AM, almost 24 hours after the initial request and identification of the change in condition. These findings were reviewed with the current facility DON, staff #2 on 10/16/24. She stated that she saw this also during her review and has since reviewed this with the medical director who has spoken to staff MD #21 and staff CRNP #7. Cross reference F713 2. Review on 10/16/24 at 9:37 AM of the facility reported incident regarding Resident #17 and an unwitnessed fall. Resident #17 was just admitted to the facility and in less than 24 hours on the morning of 11/6/22 at 6:45 AM was found to of had an unwitnessed fall, reportedly due to restlessness and confusion. Resident #17 had initial reports of pain 4/10. The on-call physician was notified and ordered for x-rays and to administer Tylenol for pain. According to Resident #17's medication administration record (MAR) s/he received 1 dose of their regularly scheduled Tylenol, which was signed off at 8 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Masonic Homes Ltd	300 International Circle Cockeysville, MD 21030

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the nursing progress notes a change of condition was completed at 11:57 AM. This documented that Resident #17 continued to be in pain, that the family was present and was concerned about the ongoing pain. Per the assessment completed by the nurse Resident appears to be uncomfortable; s/he is stating that s/he is in a lot of pain, asking staff repeatedly to help relieve his/her left hip pain. Left hip/leg is swollen, very tender to touch- Ice packs applied to area. Resident #17 was ordered then to be sent out to the hospital 911 with a noted increased blood pressure and heart rate of 101. Per review of the hospital admitting paperwork, s/he was admitted to the hospital on 11/6/22 at 1:18 PM with a hip fracture, over 6.5 hours after s/he was initially found on the floor and only administered Tylenol with reports of increased pain. The findings on the facility investigation were that there was a delay in treatment, staff failed to transfer the resident to the hospital when there was a delay in the arrival of the x-ray technician and an increase reported in the resident's pain. The concurrent findings of the survey team were reviewed with the current DON and Administrator on 10/18/24 at 12:30 PM and again during exit on 10/21/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Masonic Homes Ltd	300 International Circle Cockeysville, MD 21030

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 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. 30428 Based on medical record review of a facility reported incident and interview with facility staff, it was determined that the facility failed to ensure that a physician was responsive to the emergency needs of residents on a 24-hour basis. This was evident during the review of 1 of 5 (#1) incidents where the physician was contacted after hours. The findings include: Review of the facility reported incident (FRI) on 10/16/24 at 11:30 AM for Resident #1 revealed a noted change in condition identified by the RN on duty, staff #5, that was sent to the on-call provider, MD, staff #21. RN staff #5 reported that Resident was exhibiting signs and symptoms of pain and discomfort, continually removing his/her oxygen and has episodes of agonal breathing .no longer eating or drinking. Is it possible to have an order for Morphine or some type of narcotic pain killer to keep him/her comfortable? This was sent on 8/7/24 at 11:31 AM under urgency -1 hour. At 11:42 AM on 8/7/24, MD staff #21, responded Please reach out to staff CRNP #7 as she is the first point of contact in E-medical. The concern and change in condition were resent to staff CRNP #7 at 11:49 AM under Urgency-1 hour. The message was escalated at 12:49 PM, 1:04 PM, 1:19 PM and finally at 3:00 PM on 8/7/24 a response came to continue with Resident #1's ordered Ativan. There was a statement in the facility investigation from staff RN #5 that she did receive a verbal order for Morphine around 3pm on 8/7/24 from CRNP #7, however it was not available. The medication was not administered to Resident #1 until 8/8/24 at 10:02 AM, almost 24 hours after the initial request and identification of the change in condition. These findings were reviewed with the current facility DON, staff #2 on 10/16/24. She stated that she saw this also during her review and has since reviewed this with the medical director who has spoken to staff MD #21 and staff CRNP #7. Cross reference F697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215361	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Masonic Homes Ltd	300 International Circle Cockeysville, MD 21030

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 0715 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the physician properly assigns and delegates tasks to a qualified dietitian (or other qualified nutrition professional); or to a qualified therapist. 42886 Based on medical record review and interview, a facility provider failed to refer a resident's case to a dietitian when the resident required additional supplementation (resident #30). This was evident for 1 of 30 residents reviewed during a complaint survey. Findings includes: On 3/27/24, the State of Maryland's Office of Health Care Quality received a complaint which alleged the facility failed to monitor resident #30's status and well-being during his/her stay in the facility. Review of resident #30's medical record on 10/17/24 at 8:11am revealed the resident was ordered to be weighed monthly. The resident's weight on 6/14/22 was 124 lbs. The resident's weight on 7/2/22 was 104 lbs. Review of the nutritional assessment on 8/4/22 revealed the assessment was done as part of readmission protocols after the resident was readmitted to the facility after being transferred to a local hospital after a fall on 7/4/22. The resident's weight had increased to 108.4 lbs. after the hospital stay. The assessment also revealed that the resident was given a PEG tube, a feeding tube that used to provide nutrition to residents that are unable to eat or cannot swallow safely. Continued review of resident #30's medical record on 10/17/24 at 11:30 am revealed that Certified Registered Nurse Practitioner (CRNP) #15 assessed the resident an average of twice a week for the month of June 2022. A review of CRNP #15's reports during this time period revealed no evidence that the resident had any weight loss. CRNP #15's reports for June 2022 stated that the resident had issues with swallowing difficulties and dehydration which were initially treated by encouraging increased oral intake of thickened liquids and eventually the resident was hydrated by IV fluid. There was no evidence that CRNP #15 referred the resident's case to a dietitian for increased nutritional supplementation. The surveyor interviewed CRNP #15 on 10/18/24 at 2:18pm. CRNP #15 confirmed that he/she provided care to resident #30 in the month of June 2022. CRNP #15 also confirmed that the resident was being treated for several conditions including COVID 19 and a urinary tract infection during the month of June 2022. CRNP #15 stated that facility nursing staff failed to inform him/her of the resident's poor oral intake causing the resident to lose weight. The surveyor informed the administrator and the Director of Nursing (DON) of the deficient practice on 10/21/24 at 11:00am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE 300 International Circle Cockeysville, MD 21030	

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on medical record review and interview it was determined that the facility failed to follow the standard of practice of verifying medication doses when ordering and administering medication. This was evident during the review of a facility reported incident where a resident was administered an inappropriate dose of morphine. This was evident for 1 of 3 Residents reviewed (#1) for deaths. This failure resulted in an Immediate Jeopardy for Resident #1. The facility implemented effective and thorough corrective measures following this incident. The facility's plan and action were verified during this survey, therefore this deficiency will be cited as past noncompliance. The date of correction was [DATE]. The findings include: Review of the facility reported incident on [DATE] at 11:30 AM revealed concerns regarding the medication administered to Resident #1 was noted with a decline during his/her stay in the facility. Resident #1 was ordered Ativan for agitation on [DATE] secondary to increased oxygen requirement. At this time a hospice consult request was put in. On ,d+[DATE] at 11:31 AM, according to a nursing progress note, Resident #1 was noted with dyspnea and agonal breathing (shortness of breath and irregular, labored or gasping breaths). An E-medical (electronic communication) was sent to the on-call physician requesting for some type of narcotic pain killer to keep [resident] comfortable. Certified Registered Nurse Practitioner (CRNP) #7 responded at 3PM, 3 hours after the initial E-medical was sent, to continue the Ativan as she was waiting to hear back from the unit manager regarding hospice care. According to the facility investigation and statements, RN #5 stated that just after she received the E-medical for the Ativan, she then took a verbal order over the phone from CRNP #7 for Morphine 5mg to be given every 2 hours for pain and shortness of breath. RN #5 in a statement for the facility investigation stated that the verbal order was for 5 mg of Morphine for administration every 2 hours, which would be .25 ml dose from a 20 mg/ml concentration that was to be ordered. However, RN#5 wrote 2.5ml in the electronic order not . 25ml (2.5 would be a 50 mg dose). She further stated that she had not administered the medication because it was not available but would have immediately noted that the order was wrong when she went to administer it, that 2.5ml was incorrect. Agency LPN #11 signed for the Morphine when delivered from the pharmacy on [DATE] and placed it in the narcotic box. The prescription sticker on the controlled drug receipt form stated Morphine concentration 20 mg/ml. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER: Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 International Circle Cockeysville, MD 21030	

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nursing progress notes and according to the medication administration record (MAR), on [DATE] at 10:02 AM Resident #1 was noted with shortness of breath and was administered the Morphine as ordered on the MAR, a concentration of 10mg/5ml of Morphine, 2.5 ml. This dosage calculated out to 5mg, the expected dosage. However, according to the C-2 form requested by the physician, and the controlled drug receipt signed by LPN #11, the pharmacy delivered a concentration of 20 mg/ml vial of Morphine. According to the controlled drug receipt/record/disposition form, LPN #6 signed off at 10:02 AM and 9:23 PM she pulled and administered 2.5 ml of the 20 mg/ml concentration of Morphine which for Resident #1, calculated to a 50mg dose, 10 times the ordered dose. To administer 2.5 ml, LPN #6 would have needed to draw up and fill the pharmacy provided syringe 2.5 times as only a 1ml size syringe is delivered with that concentration of Morphine. This was confirmed during a tour and observation of the medication cart on [DATE]. At 1:40 AM on [DATE] Resident #1 was pronounced deceased . Interviews with 4 of 4 staff on 2 of 2 floors on [DATE] revealed that they still take verbal orders from physicians. Medication administration education was completed with the staff on [DATE] and [DATE] according to training documentation provided by the facility on [DATE]. At 12:57 PM on [DATE] the survey team reviewed the identified concerns with the Administrator, DON and ADON regarding the inappropriate medication administration. On [DATE] the facility presented to the survey team a plan of correction that was implemented on [DATE] with a final date of compliance of [DATE]. This plan was verified on site on [DATE]. Their plan included that all controlled substance orders requiring written authorization will be reviewed to ensure controlled substance written order forms and electronic orders in the electronic medical record are correct, education on medication administration to all licensed nursing staff, controlled substance order forms requiring written authorization order forms will be reviewed every shift, then reviewed daily then weekly x 3 months. There will also be daily checks of inventory records daily for 30 days and monthly for 3 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Masonic Homes Ltd	300 International Circle Cockeysville, MD 21030

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 30428 Based on facility document review and interview, it was determined that the facility administration failed to follow the guidelines for abuse investigation which included conducting complete and thorough investigations, identifying abuse and putting in appropriate interventions to prevent further occurrences of abuse. These failures placed all residents at risk for abuse. This was evident for 4 of 4 (#6, #7, #2 and #10) facility reported incidents reviewed completed by the previous facility Director of Nursing. The findings include: 1. Review on 10/17/24 at 11:55 AM of the FRI regarding Resident #6 an allegation of verbal abuse revealed that residents' family member reported to the (previous) facility DON, staff # 18, on 6/14/24 that staff were rude when delivering residents breakfast trays. The concern was further noted that staff would leave the breakfast trays in front of the resident and then would not assist the resident right away with eating. Record review at 12:30 PM on 10/17/24 revealed that Resident #6 was dependent on staff for meals and eating as noted in his/her care plan and in the daily nursing progress notes. On 6/20/24 a care plan meeting was held. That same family member, Resident #6's representative, asked the DON what the follow-up was to his reported concern about verbal abuse. According to the statement in the FRI, the DON did not feel the concern from the family member rose to the level of verbal abuse and no official investigation was initiated. It was not until 6/20/24 that an investigation into the care Resident #6 received on 6/14/24 was addressed, although the family reported concerns about breakfast delivery and staff to resident interactions. The concern that the previous DON failed to identify reported concern as a form of potential abuse and elevate them to an investigation and then further was not reported for another 6 days was reviewed with the current DON and NHA throughout the survey and again during exit on 10/21/24. cross reference F550, F609, F610 2. Review of a facility reported incident (FRI) regarding Resident #7 on 10/18/24 at 12:27 PM revealed a fall which was the 6th in a month and the second requiring hospitalization . This fall was documented as occurring in the common area, according to a statement from the on-duty nurse that day who did not observe the fall but documented seeing the resident afterwards on the floor. Resident #7 was sent to the hospital and diagnosed with a compression fracture of the thoracic vertebrae. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER: Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 International Circle Cockeysville, MD 21030	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility 5-day follow-up investigation report form noted that there were no staff or resident interviews conducted. Additionally, section 3, the conclusion was noted as N/A under not verified and section 4 for corrective action taken was left blank. This was signed and submitted by staff #18, the previous DON. The concern that there was no conclusion or preventative measures presented was reviewed with the administrative team which included the DON, Administrator and ADON on 10/18/24 and again during exit on 10/21/24. Cross reference F610 3. Review on 10/16/14 at 10:45 AM of the FRI for Resident #2, revealed that on 8/10/24, Resident #2 reported to LPN #20 concerns related to possible abuse from GNA's that had provided him/her with activities of daily living. However, it was not until 8/14/24 that staff LPN #20 reported this concern to the (previous) DON #18. This concern was completed on a grievance form and the identified staff were educated on customer service training, not abuse or timely reporting of abuse. These collaborative concerns were reviewed with the current facility administration throughout the survey. Cross reference F609 4. Review of the FRI for Resident #10 on 10/18/24 at 10:37 AM revealed on 11/7/23 Resident #10 notified staff that s/he was not being treated well, that a GNA was being pushy and rushing him/her with care. This was immediately reported to the (previous) DON. The results of the concern form completed by the DON stated in actions: assignment change for employee, I reassured patient that GNA would be educated on customer service. On 11/9/23 another concern form was completed for Resident #10. The Social worker reported that the patient had continued concerns reflecting back from the previous Tuesday and Wednesday (7th and 8th), as previously reported, that the aide was rough and yelling at him/her. The documented facility follow-up from the previous DON was GNA re-educated on customer service and having a team member assist with repositioning, GNA educated and assignment on unit has been changed. A report was not sent to the Office of Health care Quality until 11/9/23 at 4:22PM by the facility DON. It was documented on the form that she notified the NHA that she was just notified at 2:30 PM on 11/9/23 by the social worker that Resident #10 had concerns about a GNA being pushy while providing care. The interventions included updating the resident care plan, education to the staff, interviews and changing the employes schedules. The facility report was submitted as mental/verbal abuse. According to the facility report there were 2 GNAs identified of concern. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER: Maryland Masonic Homes Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 International Circle Cockeysville, MD 21030	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The documented facility follow-up from the previous DON was GNA re-educated on customer service and having a team member assist with repositioning, GNA educated and assignment on unit has been changed. A review of the schedules for 11/9/23-12/1/23 revealed only 10 of 26 days where Resident #10 was not in the presence of either identified employee that s/he had concerns and allegations of abuse against from 11/7-12/1/23 The initial allegation was made on 11/7/23. On 11/8/23, 11/9, 11/12, 11/20, 11/21, 11/23, 11/25 and 11/30 one of the 2 GNAs was assigned to Resident #10. On 11/11, 11/22, 11/26, 11/28 and 11/29 one of the 2 GNAs was caring for residents in adjacent rooms. There was no evidence that either GNA was suspended pending investigation, or that there was any preventative action put in place to prevent further occurrences of potential abuse to Resident #10. The concern that the DON was aware of the incident on 11/7/23 and dismissed it as a customer service issue was reviewed with the current facility DON on 10/18/24 at 12:10 PM. cross reference F609, F610