STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215363	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lutheran Village at Miller's Grant	9120 Fathers Legacy Ellicott City, MD 21042

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. Based on record review, observation and interviews, it was determined that the facility staff failed to provide nursing care within the standards of practice by (1) failed to implement fall prevention interventions, and (2) inaccurately documented an intervention that was not implemented. This was evident for 1 (Resident #5) of 2 residents reviewed for falls during the recertification survey. The findings include: On 6/23/25 at 10:00 AM, a review of Resident #5's medical records was conducted. The review revealed that the resident had sustained a fall in the facility. The resident had a care plan with interventions that included floor mats and hip protectors while in the wheelchair. Further review of records revealed an active order for Resident #5 to have hip protectors when sitting in a wheelchair at all times. On 6/23/25 at 10:28 AM, Resident #5 was observed sitting in a wheelchair with no hip protectors. On 6/23/25 at 12:40 AM, Resident #5 was observed sitting in a wheelchair in the living room area near the nurses' station. The resident had no hip protectors. On 6/23/25 at 12:41 PM, an interview with Staff #1 was conducted. When asked if the resident should have hip protectors when sitting in a wheelchair, the staff responded yes. Staff #1 confirmed that the resident did not have hip protectors as ordered. On 6/25/25 at 01:07 PM, Resident #5 was again observed in the dining area without hip protectors. This observation was verified by Staff #4 who at the time was assisting the resident with meals. On 6/25/25 at 01:15 PM, an interview with Staff #3 was conducted. She confirmed that the resident did not have hip protectors on. When asked if the resident should have hip protectors while sitting in the wheelchair, Staff #3 stated that the hip protector order had been discontinued a while ago. On 6/25/25 at 01:26 PM, an interview with the Director of Nursing (DON) was conducted. She confirmed that the hip protectors order was an active order and that the resident should have the hip protectors on while in the wheelchair. Furthermore, the DON also reported that Staff #3 had documented that she placed hip protectors on the resident in the morning. DON was made aware of the identified concerns.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, it was determined that the facility failed to: (1) discard expired food products, and (2) properly label food products with an expiration/use by date. This was evident during the initial tour of the kitchen and had the potential to affect all residents. The findings include: On 6/23/25 at 07:59 AM, a brief tour of the kitchen was conducted. The surveyor was accompanied by the facility's Chef, Staff #5. A brief interview with Staff #5 was conducted. When asked if food products should have an expiration date, he responded that it was the facility ' s expectation that all products have a use-by date. Additionally, Staff #5 stated that it's the facility ' s practice to discard expired items. A tour of the dry storage room revealed 3 bags of bread rolls that had an expiration date of 6/16/25. In each bag there were about 10 rolls. One bag was observed to have black-blue-greenish rolls. Additionally, the surveyor observed several fruit cocktail and artichoke hearts containers that had no expiration dates. There was a container with crushed peanuts that the staff #5 acknowledged was already expired and stated, It should not be in the storage. A brief tour of the refrigerator revealed 1 large container with olives and another container with shallots that had no expiration dates. On 6/24/25 at 09:55 AM, the Director of Nursing (DON) and facility administrator were made aware of the above findings.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and interview, it was determined that the facility failed to ensure there was a system in place to ensure Geriatric Nursing Assistants (GNAs) completed 12 hours of in-service training annually. This was evident for 4 (GNA/Staff #6, GNA/Staff #7, GNA/Staff #8, and GNA/Staff #9) of 5 GNAs reviewed during the annual survey. The findings include: 1) On 06/24/25 at 09:53 AM, review of GNA/Staff #6's annual 12 hour GNA training provided by the facility revealed 0.5 hours completed in 2024. 2) On 06/24/25 at 09:53 AM, review of GNA/Staff #7's annual 12 hour GNA training provided by the facility revealed 0 hours completed in 2024. 3) On 06/24/25 at 09:53 AM, review of GNA/Staff #8's annual 12 hour GNA training provided by the facility revealed 0 hours completed in 2024. 4) On 06/24/25 at 09:53 AM, review of GNA/Staff #9's annual 12 hour GNA training provided by the facility revealed 0 hours completed in 2024. On 06/25/25 at 01:11 PM, the surveyor reviewed the concern with the Nursing Home Administrator. She agreed the facility was not in compliance for the 4 GNAs noted above.