STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215348	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Taneytown, Inc	100 Antrim Blvd Taneytown, MD 21787

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. Based on record reviews and interviews, it was determined that the facility failed to thoroughly investigate allegations of abuse. This was evident for 2 (Residents #17 and #55) of 4 residents reviewed for abuse allegations. In addition, the facility failed to protect a resident during the course of an investigation, which was evident for 1 (Resident #17) of 1 resident reviewed for abuse allegations.The findings include:Resident #17 has a medical history of a stroke, resulting in hemiplegia, a condition that causes paralysis or weakness on one side of the body. The resident has a Brief Interview for Mental Status (BIMS) score of 15, indicating no or very little cognitive impairment, suggesting intact thinking and memory. On 9/23/25 at 2:30 PM, the Surveyor reviewed records related to a facility-reported event (FRI) indicating that Resident #17 reported to the facility on 6/26/25 at 1:30 PM that two Geriatric Nursing Assistants (GNAs) had been rough with them when providing incontinence care. The aides reportedly stated that s/he was the equivalent of two people, referencing their weight. The resident further reported that the head of nursing got in on the deal, stating, Have you tried to lift your weight recently? They described feeling like a piece of meat and said, How dare they stand on two legs with two arms and treat me that way. S/he expressed that they did not want to be in that condition and worried about whether they would walk again. The facility obtained statements from Resident #17 and the two GNAs alleged to have been rough, but the investigation did not show evidence that other staff members or residents (aside from the roommate, who stated they were not aware of the incident) were interviewed. The facility suspended the two GNAs during the investigation, but there was no clarification regarding who the head of nursing was or whether that person was suspended. The facility ultimately found the claim unsubstantiated without conducting a full investigation. On 9/23/25 at 3:14 PM, the Surveyor interviewed the Director of Nursing (DON), who confirmed familiarity with the complaint and identified the head nurse as the Unit Manager (Nurse #8). When asked why Nurse #8 was not suspended along with the other alleged perpetrators, the DON stated it was because in an email she indicated she was joking. The DON acknowledged in retrospect that all three staff members should have been suspended during the investigation. When asked whether there was evidence that other residents or staff were interviewed, the DON stated she did not see any in the file. The Chief Clinical Officer (CCO), who joined the conversation, offered to provide the facility with an investigation template, emphasizing that abuse allegations should include interviews with other residents and staff to determine if others witnessed the event or had similar concerns. The DON indicated she would further investigate to determine if additional interviews were conducted. On 9/24/25 at 8:38 AM, the DON informed the Surveyor that no additional residents or staff were interviewed as part of the investigation and provided the email from Nurse #8 claiming she was joking (continued on next page)

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the resident about their weight. On 9/24/25 at 9:31 AM, the Surveyor spoke with the DON and CCO and reviewed the investigation findings, including Nurse #8's email confirming the joke about the resident's weight, the lack of suspension for Nurse #8, and the absence of interviews with other staff or residents. After this review, the DON acknowledged that the allegation had not been thoroughly investigated in accordance with regulatory guidelines 2) On 9/24/25 review of facility reported incident 335697 revealed that on 3/29/23 Resident #55 reported having received rough care that morning from GNA #6. Review of the facility's investigation documentation revealed documentation of an interview with Resident #55 and a handwritten statement completed and signed by GNA #6 on 3/29/25. No documentation was found to indicate other interviews were conducted in regard to this allegation. On 9/24/25 at 3:58 PM interview with the Director of Nursing (DON) revealed that the Nursing Home Administrator (NHA) usually conducts the abuse investigations but when the NHA is not here then it goes to her (the DON). When asked to describe what is involved in an investigation, the DON included getting statements from the resident, other residents and staff working at the time and potentially family. The DON confirmed that she would interview more than just the resident and the accused. Surveyor then discussed the concern that, based on review of the documentation provided, the only interviews conducted in relation to Resident #55's allegation, was Resident #55 and the accused GNA. As of time of survey exit on 9/25/25 at 2:15 PM no additional documentation was provided in regard to this concern.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. During the initial tour of the facility on 09/22/2025, at 9:06 AM, Residents #67 and #17 reported that the facility's food was bland and cold for foods that needed to be warm. An observation of the facility's lunch tray line service was conducted on 9/22/2025 at 12:30 PM. The surveyor requested a test tray at that time. The tray contained Roast beef, steamed vegetables, one dinner roll, margarine, pumpkin pie, vanilla ice cream, cranberry juice, roasted red potatoes, salt, and pepper.Staff #12, the Dietary Director, who was present, took the temperatures of the food items, which showed 137 degrees for the steamed vegetables, 121 degrees for the roasted potatoes, 146 degrees for the Roast beef, 63 degrees for the pumpkin pie, and 61 degrees for the cranberry juice. Staff #12 indicated that the acceptable temperatures should have been 140-165 degrees F for the steamed vegetables, 140-165 degrees F for the roasted potatoes, 40 degrees F or less for the pumpkin pie, and cranberry juice. A review later that day of the facility's policy and procedure on food preparation and service contained a statement that while food is being stored, prepared, served or transported to the residents, it is protected from contamination. It is necessary to keep foods refrigerated below 45 degrees F and heated to temperatures above 140 degrees F to prevent the growth of any pathogenic organisms. However, earlier observations of a test tray, taken directly from the food service line, showed temperatures lower than 140 degrees for foods that required warming and over 45 degrees for foods that needed to be kept cold.In an interview on 9/23/2025, at 4:51 PM, staff #12 reported that she would provide training to her staff on the proper temperatures of the food served to residents.