STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, it was determined that the facility failed to notify resident's representative of a change in condition. This was evident for 1(Resident #8) of 1 resident reviewed in a complaint investigation.The findings include: On 8/26/2025 at 11:57 AM, during a telephone interview, Resident #8's Representative expressed surprise that the Foley catheter was discontinued without notification, stating it was previously deemed necessary. The representative emphasized, the facility doesn't call me at all! On 08/26/2025 12:44 PM, a review of Resident #8's progress from 8/1/25, indicated Foley came out. Provider was made aware. Provider has ordered a voiding trial. However, the note did not include any mention of the Resident #8's Representative being notified. On 8/27/2025 at 9:46 AM, Licensed Practical Nurse (LPN #18) confirmed that the nurses were expected to notify both the Physician and the Resident's Representative about any change of condition or order changes, and to document these notifications in the medical record. On 8/27/2025 at 9:56 AM, the Director of Nursing (DON) confirmed the requirement for nurses to contact the physician and the resident's representative regarding any change in resident status. The DON acknowledged this concern and stated that an in-service training would be conducted immediately.

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
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews, record reviews and observations, it was determined that the facility failed to ensure that all alleged violations involving abuse are reported immediately. This was found to be evident for 3 (Resident #6 , #91 and #107) out of 3 Residents reviewed for reporting abuse allegations. The findings include: 1. On 08/20/2025 at 8:30 AM, this surveyor conducted an interview with Resident #6 and #91. The Resident's both reported that approximately one week prior, an individual entered their room, pulled up the individual's gown, and exposed themselves, appearing to seek sexual contact. Resident #6 and Resident #91 provided descriptive information about the individual and reported that he/she believed the person to be another resident living on the unit. Resident #6 also reported that this individual had previously urinated in the hallway. On 08/20/2025 at approximately 10:30 AM, this surveyor conducted an interview with the Administrator and the Chief Nursing Officer. The surveyor made them aware of the statements provided by Resident #6 and Resident #91 regarding an allegation of sexual abuse. On 08/20/2025 at 2:15 PM, the Administrator provided documentation to this surveyor regarding Resident #6 and Resident #91. On 08/20/2025 at 2:16 PM, this surveyor reviewed the records provided. The documentation included statements from Resident #6 and Resident #91, an interview statement with the alleged individual, Resident #108. A sheet signed by Geriatric Nursing Assistant (GNA) #2 and GNA #28 which indicated “Employees in Incident Area Having No Knowledge of Incident.” The documentation also included a witness statement from Unit Manager #4 discussing the incident with Resident #6. On 08/20/2025 at approximately 2:20 PM, this surveyor conducted a follow-up interview with the Administrator. The Administrator confirmed that the documents provided represented all records related to the information collected for the sexual abuse allegation reported by the residents to the surveyor. She clarified that the facility was not conducting its own investigation at this time, and that the documentation was provided solely to assist the surveyor with the investigation. On 09/03/2025 at approximately 9:30 AM, this surveyor conducted an interview with the Administrator and inquired whether a report had been made to the Office of Health Care Quality (OHCQ) regarding the allegations of sexual abuse reported by Resident #6 and Resident #91. The Administrator reported that no such report had been made. The surveyor informed the Administrator that this concern would be brought back to the office for further review. 2. During a phone interview conducted on 08/22/2025 at 8:29 AM, Resident #107's Representative reported that the Resident's roommate verbally abuses the Resident with threats routinely. The Representative stated the threats have upset the Resident and that he/she had reported the threats to the facility in the Care Plan meetings however nothing had been done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 - Some	During an interview conducted on 08/22/25 at 8:35 AM, this Surveyor reported to the Nursing Home Administrator (NHA) that Resident #107's Representative reported that the Resident's roommate had been threatening the Resident. The Resident's Representative had also reported that he/she reported the concern of the roommate threats in the Care plan meetings. During an observation conducted on 08/22/25 at 8:47 AM, Resident #107 stated “roommate mean, I don't know why.” The Resident was visibly upset when speaking about the roommate. On 08/22/25 at approximately 11:30 AM, the NHA returned and stated that she reviewed the Care Plan meetings notes and that there is no documentation of the threats. She also stated that she spoke with Unit Manager #4 who advised she was aware of a situation that upset Resident #107 because the Resident's roommate (Resident #115) pushed Resident #107 in a wheelchair. During an interview conducted on 09/03/25 at approximately 9:00 AM, this Surveyor asked the NHA had she reported the allegation of verbal abuse to the Office of Health Care Quality (OHCQ). The NHA responded no because she had discovered and reported to this Surveyor that the only incident that occurred was when the Resident #115 pushed Resident #107 in a wheelchair. This Surveyor asked if she had interviewed the Resident regarding the Surveyor reported allegation she stated no. This Surveyor advised that when Surveyors report to the NHA that they have been advised of an allegation of any form abuse, the facility is required to report the allegation to OHCQ, and a thorough investigation is conducted. The NHA stated that she would report the allegation now (09/03/25).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 - Some	Respond appropriately to all alleged violations. Based on interviews, record reviews and interviews, it was determined that the facility failed to ensure that all alleged violations involving abuse are investigated. This was found to be evident for 3 (Resident #6, #91 and #107) out of 3 Residents reviewed for investigating abuse allegations. The findings include: 1. On 08/20/2025 at 8:30 AM, this surveyor conducted an interview with Resident #6 and #91. The Resident's both reported that approximately one week prior, an individual entered their room, pulled up the individual's gown, and exposed themselves, appearing to seek sexual contact. Resident #6 and Resident #91 provided descriptive information about the individual and reported that he/she believed the person to be another resident living on the unit. Resident #6 also reported that this individual had previously urinated in the hallway. On 08/20/2025 at approximately 10:30 AM, this surveyor conducted an interview with the Administrator and the Chief Nursing Officer. The surveyor made them aware of the statements provided by Resident #6 and Resident #91 regarding an allegation of sexual abuse. On 08/20/2025 at 2:15 PM, the Administrator provided documentation to this surveyor regarding Resident #6 and Resident #91. On 08/20/2025 at 2:16 PM, this surveyor reviewed the records provided. The documentation included statements from Resident #6 and Resident #91, an interview statement with the alleged individual, Resident #108. A sheet signed by Geriatric Nursing Assistant (GNA) #2 and GNA #28 which indicated “Employees in Incident Area Having No Knowledge of Incident.” The documentation also included a witness statement from Unit Manager #4 discussing the incident with Resident #6. On 08/20/2025 at approximately 2:20 PM, this surveyor conducted a follow-up interview with the Administrator. The Administrator confirmed that the documents provided represented all records related to the information collected for the sexual abuse allegation reported by the residents to the surveyor. She clarified that the facility was not conducting its own investigation at this time, and that the documentation was provided solely to assist the surveyor with the investigation. On 09/03/2025 at approximately 9:30 AM, this surveyor conducted an interview with the Administrator and inquired whether the facility had reported the allegations of sexual abuse, as described by Resident #6 and Resident #91, to the Office of Health Care Quality (OHCQ). The Administrator confirmed that the facility had not initiated an official investigation or submitted a report to OHCQ. The surveyor informed the Administrator that this concern regarding lack of investigation, and would be referred to the OHCQ for further review. 2. During a phone interview conducted on 08/22/2025 at 8:29 AM, Resident #107's Representative reported that the Resident's roommate verbally abuses the Resident with threats routinely. The Representative stated the threats have upset the Resident and that he/she had reported the threats to the facility in the Care Plan meetings however nothing had been done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 - Some	During an interview conducted on 08/22/25 at 8:35 AM, this Surveyor reported to the Nursing Home Administrator (NHA) that Resident #107's Representative reported that the Resident's roommate had been threatening the Resident. The Resident's Representative had also reported that he/she reported the concern of the roommate threats in the Care plan meetings. During an observation conducted on 08/22/25 at 8:47 AM, Resident #107 stated “roommate mean, I don't know why.” The Resident was visibly upset when speaking about the roommate. During an interview conducted on 08/22/25 at 8:52 AM, Geriatric Nursing Assistant (GNA) #5 was asked if she was aware of any conflicts with Resident #107. The GNA stated that Resident 107's roommate Resident #115 continuously threatens and upsets Resident #107. The GNA stated that the staff asked that the roommate, Resident #115 be moved out of the room however nothing had been done. On 08/22/25 at approximately 11:30 AM, the NHA returned and stated that she reviewed the Care Plan meetings notes and that there is no documentation of the threats. She also stated that she spoke with Unit Manager #4 who advised she was aware of a situation that upset Resident #107 because the Resident's roommate (Resident #115) pushed Resident #107 in a wheelchair. During an interview conducted on 09/03/25 at approximately 9:00 AM, this Surveyor asked the NHA had she reported the allegation of verbal abuse to the Office of Health Care Quality (OHCQ). The NHA responded no because she had discovered and reported to this Surveyor that the only incident that occurred was when the Resident #115 pushed Resident #107 in a wheelchair. This Surveyor asked if she had investigated the Surveyor reported allegation of abuse and interviewed the Resident, the NHA responded no. This Surveyor advised that when Surveyors report to the NHA that they have been advised of an allegation of any form abuse, the facility is required to report the allegation to OHCQ and conduct a thorough investigation. The NHA stated that she would report the allegation now (09/03/25) and investigate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews it was determined that the facility failed to (1) implement recommendations made by the wound care team to treat pressure ulcers and (2) failed to initiate care upon admission for a resident with a pressure ulcer. This was evident for 2 (Residents #116 & #131) of 2 residents evaluated for pressure ulcer care during the survey.The findings include:1) A pressure ulcer, also known as a bed sore or decubitus ulcer, is a localized area of skin damage that develops when prolonged pressure or shear forces disrupt blood flow to the tissues resulting in damage to the underlying tissue. Pressure ulcers are staged based on their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full-thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater) or Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon).A Deep tissue injury (DTI) is a type of pressure injury that occurs when prolonged pressure or shear forces damage the underlying tissues, such as muscles, bones, and tendons. During a medical record review for Resident #116 on 8/19/25 at 6:22 PM it was discovered that a Wound Care provider's Wound Note from 6/17/25 reported the resident had a Stage III pressure ulcer and made the recommendation for the resident to have an air mattress for pressure redistribution.A review of Resident #116's wound care notes conducted on 8/19/25 at 6:30 PM revealed a recommendation for an air mattress for pressure redistribution on 7/29/25, 8/05/25, 8/12/25 and 8/19/25.During additional medical record review for Resident #116 it revealed the order for an air mattress was not entered into the resident's Electronic Medical Record (EMR) until 8/05/25. During an observation of the bed for Resident #116 on 8/20/25 at 7:46 AM it was discovered that the resident did not have an air mattress. During a repeat observation with Registered Nurse #13 of Resident #116 on 8/21/25 at 8:33 AM she confirmed that the resident did not have an air mattress but should have one. During an interview with Unit Manager #4 on 8/21/25 at 1:03 PM she agreed that Resident #116 should have an air mattress but did not have one at this time. She advised Wound Care recommendations are put in as orders typically the next day after wound care sees the resident. She reported she had just checked with maintenance about the air mattress and was told they had been ordered because all the air mattresses had been utilized. During an interview with Maintenance on 8/21/25 at 1:34 pm he provided a work order request that was submitted on 8/05/25 for Resident #116 to have an Air Mattress. He reported they needed more air mattresses, and he had placed a request for air mattresses to be ordered with the purchasing department on 8/18/25. He denied making any orders for air mattresses prior to 8/18/25. During an observation of Resident #116 on 8/25/25 at 10:48 AM it was discovered that the resident now has an air mattress.During an interview with the DON on 8/25/25 at 11:17 AM she confirmed there was a delay in the order for the air mattress being placed for Resident #116 and is not sure what the delay may have been since she is new to the facility. She reported it appeared the process might not have been followed through.2. During a medical record review for Resident #131 on 9/02/25 at 7:58 AM it was discovered that the resident was admitted to the facility on [DATE] with a pressure injury. The transferring Hospital Discharge Summary reported, current inpatient wound care order - Wound care dressing 2 times daily: Pannus and Coccyx - keep clean and dry. Turn and reposition every 2 hours. Apply Zinc paste twice a day. When cleansing incontinence away. Do not attempt to remove all of the barrier cream. Reapply Zinc cream as needed to maintain a protective coating over the area. The Discharge paperwork identified the Coccyx wound as a Pressure injury that had started on 2/13/25.During continued medical record review for Resident #131 it was revealed that the pressure injury was not identified upon admission to the facility and that there were no treatment orders placed to care for the pressure injury in the resident's Electronic Medical Record (EMR). During additional medical record review, it was discovered that a Wound Assessment Report from the Wound Care Provider dated 2/28/25 reported several wounds. The wounds included: A Pressure Ulcer/Injury that was determined to be a Deep tissue Injury to the right buttock and was listed as Present on Admission.A Pressure Ulcer/Injury that was determined to be Stage 3 to the right gluteal fold and was listed as Present on Admission.A Pressure Ulcer/Injury that was determined to be Stage 3 to the left gluteal fold and was listed as Present on Admission.A Pressure Ulcer/Injury that was determined to be a Deep tissue Injury to the right heel and was listed as Present on Admission.A Pressure Ulcer/Injury that was determined to be a Deep tissue Injury to the left buttock and was listed as Present on admission The Wound Care Providers gave recommendations for treating each wound that included, Right buttock Pressure Ulcer/Injury -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on interviews and observation it was determined that the facility failed to ensure essential equipment was operational. This was found to be evident for 2 out 2 Laundry equipment and the facility's telephone system observed during the recertification survey.The findings include: 1) During an observation conducted on 08/29/2025 at approximately 9:30 AM the Surveyor observed 1 washer in operation in the laundry room. Laundry Aide #29 stood in front of a large grey bin which was half filled with wet white linen. The Aide stated that the linen was already washed and was waiting for the load to dry so that she could place another load in the dryer. During the observation of the laundry room, it was discovered that the facility had 1 operational washer machine and 1 operational dryer machine. During an interview conducted on 09/03/25 at 2:29 PM, the Maintenance/ EVS Director reported that the facility has had 1 dryer machine operational for close to 1 year and 1 washer machine. Recently a second washer machine was delivered however the washer machine that was operational stopped working so instead of having 2 washer machines the facility is currently only able to use the 1 new washer machine. He stated that a request for service had been submitted. This Surveyor expressed concern for the washed wet laundry that was observed sitting in a bin waiting to be dried. The Maintenance/ EVS Director stated he was aware that the staff does that, and he educated the staff to not wash ahead. When asked if Laundry can keep up with the daily volume of the soiled laundry the Maintenance/EVS Director stated unfortunately they cannot. This is due to having 1 washer machine and 1 dryer machine. He stated that he runs a second shift from 4pm – 10pm to try to address the volume of soiled laundry, however during that time housekeeping mop heads, slings, and other cleaning cloths are also washed and dried. When asked how many machines were needed to fully address the daily soiled volume of laundry, the Maintenance/ EVS Director stated when the facility had 3 washer machines and 4 dryer machines all laundry was able to be cleaned in a day. When asked when the facility had 3 washer machines and 4 dryer machines he responded that the machines broke one by one through the last couple of years and had not been replaced except for the 1 new washer machine that was recently delivered. During an interview with the Nursing Home Administrator (NHA) conducted on 09/04/25 at approximately 9:45 AM, the NHA stated that she was recently made aware that 1 of the washer machines was not operational and stated that a service call had been requested. This Surveyor expressed concern that facility with a bed capacity of 170 had 1 dryer machine that was operational for close to 1 year and had 1 washer machine that was operational which cannot address the daily volume of soiled laundry even with running a second shift. During the continued interview this Surveyor expressed concern that numerous Residents had reported during the Resident Council Meeting laundry concerns in October of 2024 and in December 2024 they had multiple grievances for missing clothing items that were sent to laundry but were not returned. This Surveyor also expressed concern of the observation that washed wet laundry was stored in a bin waiting to be dried. This Surveyor expressed concerned that wet laundry in a bin in the laundry room warm environment had a potential to breed microbes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) A review of a complaint for Resident #129 was conducted on 08/28/25 at 3:00 PM. The complaint dated 04/12/25 stated “I attempted to call the Director of Nursing this morning as I was told there was no one at the facility yesterday to talk to. The Director's voicemail is full, and you cannot leave a message. I was then transferred to the Social Worker whose voice mail is also full and cannot leave a message. I have asked for a return call which I have not received at this time.” During a telephone interview conducted on 09/02/25 at 5:30 PM, Resident #122's Representative stated that he/she had been unable to reach the Nursing Home Administrator (NHA) by telephone to discuss his/her concerns about missing clothing, missed medications administration, and a missed meal. The Representative reported that the NHA's voicemail is full, and he/she cannot leave a message. During an interview conducted on 09/03/25 at 8:35 AM, the Surveyor asked the NHA if there had been problems with the phone system. The NHA stated that the facility's phone system is outdated and unable to retrieve messages. She explained that front desk staff have been instructed to screen calls and take messages on her behalf. She stated, “I normally return my calls within 24 hours.” When asked how long this issue has been occurring, the Administrator stated, “This problem has been ongoing for almost a year.” The Surveyor expressed concern that Residents, Resident Representatives and Providers were unable to leave voice mail messages for facility administration with concerns for Resident care via telephone. 3. Dryer lint buildup creates a significant fire hazard because lint is highly flammable and can ignite from the dryer's heat, leading to fires. On 08/28/25 at 1:15 PM the surveyor did a walkthrough of the laundry room. The Maintenance/EVS Director and Staff # 29 were present. The surveyor observed one dryer in operation. The Maintenance/EVS Director stated that only one of the 3 dryers in the laundry room was in working condition. The surveyor asked how often the Lint screens were cleaned. He stated that Lint screens were cleaned daily and logged in a binder. Upon inspection of the log binder, there was no evidence that cleaning was being done according to the scheduled routine. There were entries for April 2025, none for May 2025 and 14 daily entries for June 2025. There were no entries for July 2025 and one entry on 8/2/25 for the month of August 2025. For the month of June, the year was documented as “202”. The Maintenance/EVS Director stated that the entry June 202 was meant to be June 2025 as the year was not completely written out. When asked for the facility's Dryer policy and cleaning schedule, the Maintenance/EVS Director pointed to an undated document in the binder with the title “Proper Equipment Care and Maintenance (Carts, Lint Trap Cleaning). ” The document stated “Dryers - *Lint Screens to be cleaned every hour. *Dryer Tops are to be cleaned weekly/as needed to prevent fires. *Inspect Dryer baskets daily for foreign objects (Silverware, Trash, Etc.) The Maintenance/EVS Director confirmed the surveyor's findings and stated that he had not reviewed the logs recently and was unaware the logs were not maintained. Immediately after the interview, the surveyor observed Staff #29 removing a large amount of lint from the dryer. On 9/02/2025 at 10:14 AM in an interview, the Administrator stated that she was made aware of the surveyor's findings by the Maintenance/EVS Director and that she had already started corrective action by conducting an in-service with the laundry staff on 8/28/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, record reviews and interviews it was determined that the facility failed to 1) maintain the nurse call system in working order. This was evident for 2 (#19 and #11) of 6 residents reviewed for call systems and 2) ensure residents had access to call bells. This was evident of 4 residents (Resident#54, #5, #14 and #40) out of 4 residents review during recertification and compliant survey process.The findings include: 1. During an initial tour of the facility on 8/19/25 at 6:27 AM, surveyors observed the call light outside of Resident #19's room flashing on and off with an audible beeping sound heard at the nurses station. At 9:54 AM, during a second random observation by this surveyor, the same call light was observed flashing in the corridor without an audible sound. In an interview on 8/19/25 at 9:40 AM, LPN #31 confirmed she was assigned to Resident #19 and stated, “the call light is broken.” In an interview on 8/20/25 at 10:28 AM, Resident #19 stated the call light had been broken for months and “the light just stays on.” Resident #19's family member also confirmed the call light had not been working for a long time and stated staff gave Resident #19 a manual bell, but the bell could not be heard from the nurses station. On 8/26/25 at 10:15 AM, this surveyor reviewed the facility's July and August 2025 work order requests in TELS, the facility's building management platform system, which showed at least 8 reports of the broken call light for the room shared by Residents #19 and #11 between 7/28/25 and 8/20/25. All work orders showed a status of “open” or “in progress,” with no evidence the repairs were completed. In an interview on 8/26/25 at 2:35 PM, the Administrator stated she became aware of the broken call light on 8/18/25 and had submitted a maintenance request in the TELS system that day. The administrator confirmed that Resident #19 was given a bell to call for staff help and that staff was expected to make hourly rounds. In an interview on 8/26/25 at 11:54 AM, the Maintenance Director confirmed that the facility was aware of the broken call light in the room shared by Residents #19 and #11. The Maintenance Director stated he had tried calling the outside vendor a few times in the weeks before but did not have documentation of those calls. On 8/27/25 at 1:00 PM, the surveyor requested documents from the facility related to Resident #19's call light system repair. At approximately 1:37 PM, the Maintenance Director provided the surveyor with an email that was sent to the outside vendor on 8/27/25 at 1:11 PM by the Administrator which showed the facility requesting a service call for the broken call light. In an interview on 8/28/25 at 12:17 PM, the Maintenance Director confirmed that the outside vendor completed the service call earlier that day and provided the surveyor with a copy of the work order report. The report was reviewed to reveal that the patient station [call system] on the wall in Resident #11's bed space was broken and needed to be replaced. Continued review of the report revealed that the technician temporarily disconnected the station to stop the corridor light from flashing and wrote, “We need to order a new one and return and replace.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/3/25 at 10:06 AM, this surveyor saw the call light in the corridor on but not flashing, with no audible sound noted, confirming the call system for Resident #19 was still not working. At the time of exit conference, no additional documentation was provided to show that the repairs needed for the broken resident call system for Resident #19 were completed. 2. During an initial tour of the facility on 8/19/25 at 6:27 AM, surveyors observed the call light outside of Resident #11's room flashing on and off with an audible beeping sound at the nurse's station. At 9:54 AM, during a second random observation by this surveyor, the same call light was observed flashing in the corridor without an audible sound. On 8/26/25 at 10:15 AM, this surveyor reviewed the facility's July and August 2025 work order requests in TELS, the facility's building management platform system, which showed at least 8 reports of the broken call light for the room shared by Residents #19 and #11 between 7/28/25 and 8/20/25. All work orders showed a status of “open” or “in progress,” with no evidence the repairs were completed. In an interview on 8/26/25 at 2:35 PM, the Administrator stated she became aware of the broken call light on 8/18/25 and had submitted a maintenance request in the TELS system that day. The administrator confirmed that Resident #11 was given a bell to call for staff help and that staff was expected to make hourly rounds. .In an interview on 8/26/25 at 11:54 AM, the Maintenance Director confirmed that the facility was aware of the broken call light in the room shared by Residents #19 and #11. The Maintenance Director stated he had tried calling the outside vendor a few times in the weeks before but did not have documentation of those calls. On 8/27/25 at 1:00 PM, the surveyor requested documents from the facility related to Resident #11's call light system repair. At approximately 1:37 PM, the Maintenance Director provided the surveyor with an email that was sent to the outside vendor on 8/27/25 at 1:11 PM by the Administrator which showed the facility requesting a service call for the broken call light. In an interview on 8/28/25 at 12:17 PM, the Maintenance Director confirmed that the outside vendor completed the service call earlier that day and provided the surveyor with a copy of the work order report. The report was reviewed to reveal that the patient station [call system] on the wall in Resident #11's bed space was broken and needed to be replaced. Continued review of the report revealed that the technician temporarily disconnected the station to stop the corridor light from flashing and wrote, “We need to order a new one and return and replace.” In an interview on 9/2/25 at 10:16 AM, Resident #11 confirmed that staff had given him/her a manual bell to use. Resident #11 further stated, “I ring the bell, but they still don't come.” On 9/3/25 at 10:06 AM, this surveyor randomly observed the call light in the corridor on but not flashing, with no audible sound noted, confirming the call system for Resident #11 was still not working. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the time of exit conference, no additional documentation was provided to show that the repairs needed for the broken resident call system for Resident #11 were completed. 3. A call bell system in long-term care is a resident-initiated alert system, usually at the bedside or in bathrooms, that signals staff to provide assistance when needed. 1) On 08/19/2025 at 9:41 AM, Resident #54 was observed sitting in his wheelchair on the left side of the bed with the call bell on the right side, lying on the floor under the bed. The resident stated he could not reach the call bell. GNA #34 was notified and acknowledged the call bell was improperly placed. 2) On 08/19/2025 at 10:50 AM, the surveyor observed Resident #5 in bed with the call bell hanging on the head of the bed frame. The resident was unable to reach the call bell. During an interview, GNA #34 confirmed that the call bell is supposed to be within the resident's reach. 3) On 8/19/2025 at 11:59AM the surveyor accompanied LPN #14 to Resident #63 and observed resident's call bell hanging on the nightstand. LPN# 14 confirmed to the surveyor that the call bell is not within resident's reach. On 08/19/2025 at 12:05 PM, an interview was conducted with LPN #14 regarding the expectation for call bell placement. She stated that call bells are required to be within the resident's reach. LPN #14 then placed the call bell within Resident #63's reach. The surveyor made her aware of the concern, and she acknowledged receipt. 4) On 08/20/2025 at 7:45 AM during rounds on the Chesapeake Unit, Resident #40 was observed in bed with the call bell lying on the floor. The surveyor called the Director of Nursing (DON) and accompanied her to the resident's room. The DON confirmed that the call bell was not within the resident's reach. On 08/20/2025 at 10:30 AM an interview was conducted with the Director of Nursing (DON) regarding the expectation for call bell placement. She stated that “call bells are supposed to be within residents' reach.” The surveyor made her aware of the concerns, and she acknowledged receipt, stating that “staff will be educated.” On 08/21/2025 at 12:00 PM, the surveyor informed the Administrator of the above call bell concerns and Administrator acknowledged receipt.