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	07/02/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, staff and resident interviews, and facility documentation, the facility failed to ensure staff provided incontinent care using safe techniques for 1 (#22) of 1 residents reviewed for incontinent care. Specifically, staff failed to discontinue brief removal after the resident complained of pain and failed to remove the plastic fastening tabs before pulling the incontinent brief from beneath the resident. This deficient practice resulted in a deep laceration to the resident's left posterior thigh, uncontrolled hemorrhage requiring emergency medical services, hospitalization for approximately three weeks, and treatment including transfusion of four units of packed red blood cells and three units of platelets.Findings include:Intake # 3008785 was reviewed on 6/28/26 for allegations that a Geriatric Nurse Assistant (GNA # 48) roughly removed a brief pad from the resident without removing the plastic tab when providing incontinent care, causing a deep wound laceration and severe blood loss.Resident #22 is a resident with diagnoses including muscle wasting and atrophy, morbid obesity, systemic lupus (autoimmune disease), chronic respiratory failure, chronic kidney disease, chronic pain, lymphedema (abnormal swelling due to build up of protein-rich lymph fluid), atrial fibrillation (heart rhythm disorder), generalized edema, and impaired mobility. Medical record review on 6/28/26 confirmed the resident was prescribed anticoagulant therapy (blood thinner medications to prevent, breakdown, or reduce the size of blood clots).The residents' care plan, initiated on 2/22/26, identified the need for extensive staff assistance with activities of daily living and incontinent care due to obesity and impaired mobility. Interventions included providing perineal care after each incontinent episode, assisting with bed mobility, and encouraging participation in care as able.Review of the Emergency Medical Services report for 4/30/26 revealed EMS responded after facility staff reported the resident began bleeding during incontinent brief removal. Facility staff reported bleeding had continued for approximately 35-40 minutes before 911 was activated and staff were unable to identify the bleeding source or control the hemorrhage. EMS documented a large pool of blood beneath the resident, multiple blood-soaked towels, and noted the resident was receiving blood-thinning medication. During transport, the resident developed dizziness, visual changes, and decreased level of consciousness and was transported to the emergency department.The facility nursing progress note dated 5/1/26 at 3:15 a.m. documented that nursing staff were notified of severe bleeding. Assessment revealed approximately one-half of the resident's bed was covered with blood with active bleeding from the left leg. The resident's blood pressure was 99/64 with a pulse of 122. Direct pressure failed to control the bleeding. The nurse practitioner ordered immediate transfer to the hospital due to profuse uncontrolled bleeding while receiving anticoagulant therapy.During an interview on 6/28/26 at approximately 12:05 PM, Resident #22 stated two Geriatric Nurse Assistants (GNA's) were assisting with incontinence care (changing the brief pad). The resident reported staff normally removed the plastic fastening tabs before pulling the brief from underneath him/her. The resident stated s/he felt something sticking into the back of the leg and instructed GNA #48 to stop because it was painful. According to the resident, GNA #48 continued pulling the brief, causing the plastic fastening tab to cut into the back of the left thigh. The resident immediately experienced burning pain, heavy bleeding, required emergency transport, and remained hospitalized for (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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	approximately three weeks.On 6/28/26 at approximately 2:55 PM, the Clinical [NAME] President (CVP # 6) was unable to provide an investigative file regarding the incident. The only documentation later produced consisted of written statements from GNA #19 and GNA #48 and an in-service titled How to Handle Resident Safety with Fragile Skin completed only by GNA #48 on 5/27/26. No evidence was provided showing other direct care staff received education following the incident.GNA #19's written statement indicated she assisted GNA #48 during the brief change and did not observe rough handling. During interview on 6/29/26 at approximately 9:40AM, however, GNA #19 stated the resident complained of discomfort while GNA #48 was removing the brief. Because she was positioned at the front of the resident providing support, she could not see the area where GNA #48 was working. She stated GNA #48 continued removing the brief and blood immediately began squirting, prompting her to obtain the nurse.GNA #48's written statement acknowledged the resident complained of burning after the brief was removed and that significant bleeding occurred immediately afterward. During interview on 6/29/26 at approximately 10:20AM, GNA #48 further acknowledged the resident told her something was sticking him/her while the resident was turned on the side; however, she continued removing the brief before assessing the complaint. After turning the resident back, she observed profuse bleeding and notified nursing staff.The nurse supervisor (RN # 22) stated during an interview on 6/29/26 at approximately 5:22 PM, he entered the room and observed a pool of bright red blood on the resident's bed while both GNAs were applying pressure. Despite continued direct pressure, bleeding could not be controlled. He contacted the nurse practitioner and activated emergency medical services. The supervisor stated the resident informed him the injury occurred because the plastic tabs from the brief had not been removed before the brief was pulled from underneath him/her.A second nurse (#33) working at the time of the incident confirmed during telephone interview on 6/30/26 at approximately 5:00PM that Resident #22 reported GNA #48 caused the injury by pulling the brief while the plastic fastening tabs remained attached, resulting in a cut that caused burning and severe bleeding.The facility failed to ensure staff stopped the incontinent care procedure and assessed the resident after the resident complained of pain before continuing brief removal. The facility failed to ensure incontinent care was performed using safe techniques appropriate for a resident requiring extensive assistance with mobility and receiving anticoagulant therapy. As a result, Resident #22 sustained a deep laceration to the left thigh causing uncontrolled hemorrhage, emergency transport, hospitalization for approximately three weeks, multiple blood product transfusions, and actual harm.