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

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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 observation and interview, it was determined that the facility failed to ensure food was stored and prepared in a sanitary manner. This was evidenced by: (1) undated and unlabeled food items in the facility's kitchen refrigerators and freezers; (2) kitchen staff not wearing proper protective gear while preparing food for residents; (3) failure to label and date food items and monitor temperatures in all unit pantry refrigerators; and (4) water nesting on insulated plates and lids used to serve residents, as well as improper sanitization of kitchen sanitization buckets. These deficiencies were observed during the survey of the kitchen and have the potential to affect all residents.The findings include:Definitions:Tube feeding formula is a liquid mixture containing all the necessary nutrients-protein, carbohydrates, fats, vitamins, and minerals-that is delivered directly into the gastrointestinal tract via a feeding tube when a person cannot eat enough or has difficulty swallowing. Insulated plates and lids are food service equipment designed to be used together to maintain the temperature of prepared meals. They keep plates of food warm during transport from the kitchen to the facility units and while meals are being delivered to residents.Water nesting on plates refers to the presence of pooled or trapped water between stacked or inverted plates that were not allowed to fully air-dry after washing and sanitizing. This condition creates a potential for microbial growth and cross-contamination, as the plates are not maintained in a sanitary, dry manner prior to food service.Sanitization bucket - In commercial food service, a sanitization bucket is a container filled with an approved sanitizing solution used to wipe down and sanitize food contact and non-food contact surfaces. The solution must be maintained at the proper concentration, changed as needed, and the bucket must be stored in a designated location to prevent contamination.(1)On 08/19/2025 at 6:15 AM, this surveyor conducted the initial tour of the kitchen with the Dietary Manager (DM), who confirmed that she was responsible for overseeing the kitchen.On 08/19/2025 at 6:21 AM, this surveyor began the observation of the kitchen fridge and freezer. There is a sign attached to the door of the fridge that reads Everything Is To Be Dated and Labeled NO EXCEPTIONS! Remember to Clean As You Go!. There is a sign attached to the shelf inside fridge that reads Please discard all food that's more than 3 days old. There is also a sign outside the front of theOn 08/19/2025 at 6:26 AM this surveyor observed baked zucchini in the kitchen fridge that was dated 08/13/25. It was observed in the freezer section of the kitchen there was an unlabeled and undated opened package of meatballs. Pictures of the items were taken at this time. On 08/19/2025 at 6:52 AM, it was observed in the kitchen fridge that there were multiple dairy products found, sour cream with a date labeled 08/13/25, cheese labeled 08/13/25, and cream corn labeled 08/14. Pictures of these items were taken at this time. On 08/19/2025 at approximately 6:53 AM, this surveyor conducted an interview and observation with the DM. this surveyor observed with the DM the dairy products that were labeled 08/13 and 08/14. She confirmed that her expectation would be that these products should have been thrown out. On 08/19/2025 at 7:00 AM, this surveyor conducted an observation of the reach-in refrigerator. There is a sign on the front of the reach in refrigerator that states Everything Is To Be Dated and Labeled NO EXCEPTIONS! Remember to Clean As You Go!. Inside the reach in refrigerator there were 3 sandwiches that were labeled with the date 08/13. There were also several sandwiches that were (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	unlabeled and undated. On 08/19/2025 at 7:01 AM, this surveyor observed on the kitchen's bulletin board a message that stated All food must be labeled with date and stating what is in the pan, after the 3rd day if you are not using the food, you need to discard it.On 08/19/2025 at 7:06 AM, this surveyor made the DM aware of the undated and unlabeled sandwiches in the fridge, also made her aware of the date of the sandwiches. She confirmed understanding that this is a concern and reported that these sandwiches would get thrown away. (2)On 08/27/2025 at 1:52 PM, while in the kitchen, this surveyor observed Dietary [NAME] #42 not wearing a beard covering while preparing food. Shortly afterward, Dietary [NAME] #42 was observed retrieving and putting on a beard covering.On 08/28/2025 at 1:54 PM, this surveyor conducted an interview with Dietary [NAME] #42. He confirmed that he was required to wear a beard covering when preparing food.On 08/28/2025 at approximately 2:00 PM, this surveyor conducted an interview with the DM and informed her that Dietary [NAME] #42 had been observed not wearing a beard covering while preparing food. The DM acknowledged the concern, apologized, and subsequently spoke with Dietary [NAME] #42 to remind him that beard coverings must be worn while handling food. (3)On 08/27/2025 at 10:24 AM, this surveyor observed the Homestead Unit pantry refrigerator and freezer and took photographs of the contents. A sign posted on the exterior stated that the refrigerator was to be cleaned out every Monday and that all food must be labeled with the date and name. In the freezer, there was one plastic container of ice cream that was undated and unlabeled. Inside the refrigerator, there were three plastic containers of food, all undated and unlabeled. Several condiment containers were also present without labels or dates. No temperature log was posted on the refrigerator to document the temperature of the unit.On 08/27/2025 at 2:26 PM, this surveyor observed the pantry refrigerator and freezer on the Wye Oak Unit and took photographs of the contents. A temperature log for June 2025 was posted on the exterior of the refrigerator; however, no additional temperature logs were present. A sign posted on the front of the refrigerator stated the unit was for resident food only and not for staff use. The sign further outlined requirements for labeling, including the resident's name, room number, and date of placement for all opened or prepared food items. The sign stated that prepared food, such as sandwiches or pizza, could only be stored for 48 hours before being discarded, and that perishable undated items were to be discarded. Unopened items could be kept in accordance with the manufacturer's expiration date.Inside the freezer, there were five previously opened bottles of water that were undated and unlabeled. A brown substance was observed across the bottom surface. A glove that had been filled with water and frozen was present, along with paper towels adhered to the bottom surface as well. On the freezer door shelf, there were two pints of ice cream that were undated. A brown substance was also noted sprayed along the interior side of the freezer door.Inside the refrigerator, there was one plastic container of noodles, multiple opened plastic bottles, and several opened jars of pickles-all undated and unlabeled. Additional opened condiments were also present without dates or labels. Two opened bottles of Sprite were labeled with a resident's name but lacked a room number or date. A bag of oranges was observed without a date or label; several oranges inside the bag were spoiled. An opened container of iced tea and a small plastic container of fruit were present, both undated and unlabeled. A plastic bag labeled with a resident's name, room number, and date of 07/02/2025 contained spoiled grapes, bananas that were black with mold, and a container of cottage cheese. Another plastic bag, undated and unlabeled, contained multiple food items wrapped in aluminum.On 08/27/2025 at 2:41 PM, this surveyor conducted an observation of the refrigerator and freezer on the Chesapeake Unit and took photographs of the findings. A sign was posted on the front of the refrigerator indicating that the unit was to be cleaned out every Monday and that all food must be labeled with the resident's name and date. A temperature log for the refrigerator was present on the exterior; however, there was no section for tracking freezer temperatures. After looking inside the freezer, it was discovered that the freezer thermometer was positioned in the back, facing away, making it difficult to read.Inside the freezer, a brown paper bag contained food labeled with a resident's name and room number but lacked a date. A plastic bag contained Italian ice, labeled (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with a room number but no date. A plastic bag held two packaged ice cream sandwiches, labeled with a resident's name but missing a date. Inside the refrigerator, an opened reusable water bottle with a straw was present, undated and unlabeled. An opened bottle of Sprite was labeled with the resident's name and room number but lacked a date. An opened bag of salami was labeled with the resident's name but not dated. An opened container of blue cheese was labeled with the resident's name but missing a date.On 08/28/2025 at 9:25 AM, this surveyor observed the pantry refrigerator and freezer on the Mill Landing Unit and took photographs of the contents. A temperature log for June 2025 was posted on the exterior of the refrigerator; however, no additional temperature logs were present. A sign posted on the refrigerator indicated it was to be cleaned out every Monday and that all food must be labeled with a date and name.Inside the refrigerator, there were several opened or prepared food items that were undated and unlabeled. These included an open tube feeding formula container, a bottle of Caesar dressing, an opened container of nonfat Greek yogurt, a sandwich wrapped in paper, half of a sandwich wrapped in plastic, a plastic bag with food wrapped in aluminum foil, a plastic container of fruit, a plastic container of a dessert, and a plastic Tupperware container with food. In addition, there was an opened bottle of Coke and a Royal Farms bag that were labeled with a resident's name but not dated. A brown substance was observed on the interior door shelf, and the pull-out drawer at the bottom contained a brown residue adhered to the surface. Inside the freezer, there was a container of ice cream labeled with a resident's name but missing a date.On 08/28/2025 at 9:50 AM, this surveyor conducted an interview with the part-time Dietary Director. When asked to accompany the surveyor to observe the unit pantries, he stated that he did not oversee the pantries and that their management falls under nursing staff. He further indicated that nursing staff are responsible for monitoring the temperature logs.On 08/28/2025 at 9:51 AM, this surveyor conducted an interview with Licensed Practical Nurse (LPN) #1 regarding the management of the unit pantry refrigerators. She reported that aides, nursing staff, and housekeeping personnel are responsible for monitoring the refrigerators and their temperature logs. She further stated that the 11:00 PM to 7:00 AM nursing shift handles both monitoring the temperature logs and disposing of expired food and cleaning the refrigerators.On 08/28/2025 at 9:54 AM, this surveyor conducted an interview with LPN #26 regarding monitoring of the unit pantry refrigerators. LPN #26 reported that the 11:00 PM to 7:00 AM nursing shift is responsible for checking the refrigerators and maintaining the temperature logs. Environmental Services (EVS) cleans the refrigerators once a week, although he could not recall which day. LPN #26 also reported working the 11:00 PM-7:00 AM shift the previous day.On 08/28/2025 at 10:09 AM, this surveyor observed the Mill Landing unit refrigerator with LPN #26. The surveyor noted that the temperature log had last been completed in June 2025 and pointed out multiple undated and unlabeled food items. LPN #26 acknowledged the concerns and began reviewing the refrigerator to identify items to discard. On 08/28/2025 at 10:23 AM, this surveyor conducted an interview with LPN #27. She reported that she had worked at the facility for the past two months as the Unit Manager for both the Chesapeake and Wye Oak units. When asked who was responsible for maintaining the unit pantries, she stated that she was not entirely sure but believed the nurses completed this task while working. She explained that when she worked on the floor, typically during the 7:00 AM to 3:00 PM shift, she attempted to complete the refrigerator temperature logs. She acknowledged that this task had not been completed on her most recent shift. She further stated that she believed the dietary department was responsible for cleaning out food items from the refrigerators but would need to verify with administration to be sure. On 08/28/2025 at 10:34 AM, this surveyor observed the Chesapeake Unit refrigerator with LPN #27. During the observation, this surveyor identified concerns that no freezer temperatures were being logged and that the thermometer inside the freezer was positioned at the back, facing away, making it difficult to read when the door was opened. Additional concerns were noted regarding multiple opened, undated, and unlabeled food items in the refrigerator and freezer, despite the posted sign on the door requiring all items to be both labeled and dated. LPN #27 acknowledged these concerns and reported that (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	corrective action would be taken immediately. On 08/28/2025 at 10:44 AM, this surveyor conducted an interview with the Administrator regarding the maintenance of the unit pantry refrigerators. The Administrator reported that Environmental Services (EVS) was responsible for cleaning out the refrigerators once a week on Mondays, and that nursing staff were responsible for completing the temperature logs and labeling and dating food items. At this time, the Administrator was made aware of the surveyor's concerns that staff had provided multiple and inconsistent responses regarding responsibility for cleaning, temperature recording, and labeling of food. Additional concerns were raised that the refrigerators and freezers were not being properly monitored, that multiple items were either undated, unlabeled, or both, and that spoiled food had been found in the Wye Oak Unit refrigerator.The Administrator acknowledged the concerns and stated she believed this represented an education issue and a breakdown in the system. She reported that education would begin immediately, and at that time she began contacting EVS staff to instruct them to clean out the refrigerators on all units. She also stated she would meet with the Unit Managers to educate them on ensuring that temperature logs are consistently updated. (4)On 08/29/2025 at 10:51 AM, during a review of the kitchen, this surveyor observed and photographed several stacks of insulated plates and lids that were visibly wet, with evidence of water nesting.On 08/29/2025 at 10:58 AM, this surveyor made the part-time Dietary Director aware of this concern. He acknowledged the issue.On 08/29/2025 at 11:00 AM, this surveyor requested that the part-time Dietary Director test the concentration of the sanitization buckets in use.On 08/29/2025 at 11:05 AM, this surveyor observed the part-time Dietary Director test all three sanitization buckets with the appropriate test kit. The results showed that none of the buckets met the required concentration for proper sanitization. The part-time Dietary Director stated that all sanitization buckets needed to be changed.On 08/29/2025 at approximately 11:08 AM, this surveyor observed that the sanitization buckets were replaced and re-tested by the part-time Dietary Director. At that time, all three buckets met the required concentration for proper sanitization.On 08/29/2025 at approximately 1:00 PM, this surveyor was provided documentation by the part-time Dietary Director of a rack he intended to purchase that would allow insulated plates and lids to air dry, thereby preventing wet nesting and the potential for bacterial growth.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews, it was determined that the facility failed to use appropriate infection control practices such as 1) improper storage of clean linens 2) improper storage of urine specimen 3) improper storage of leftover pudding inside the medication cart and 4) failure to implement enhanced barrier precautions for residents with pressure ulcers. This was evident for 1) 1 of 1 linen cart 2) 1 of 4 medication storage refrigerators 3) 2 of 10 medication carts and 4) 2 of 2 (Residents #12 and #116) residents with wound sampled during the recertification survey.The findings include: 1) On 8/19/2025 at 6:12 AM, during an initial tour of the facility, the surveyor observed a cart in the hallway with exposed clean linens, with its cover flipped back. On 8/19/2025 at 6:18 AM, the surveyor informed Registered Nurse (RN #20) about the concern, and he/she acknowledged to cover the cart. On 8/19/2025 at 6:25 AM, a follow-up inspection was done and found that the linen cart remained uncovered. On 8/19/2025 at 6:50 AM, The Director of Nursing (DON) and the Nursing Home Administrator (NHA) were informed of this concern. 2) On 8/20/2025 at 12:01 PM, a urine sample for Resident #24 was found in the medication refrigerator in the Homestead unit storage room, together with various insulin pens. The finding was witnessed by Licensed Practical Nurse (LPN #1 and #16). LPN #1 removed the urine sample from the medication room. LPN #16 confirmed that the urine sample should have been placed in the soiled utility refrigerator. 3) On 8/20/2025 at 12:08 PM, during an inspection of Homestead medication Cart #1, the surveyor observed a leftover pudding inside a maroon plastic bowl with white plastic lid dated 8/19 for 7-3 shift inside the medication cart. Certified Medication Aide (CMA #5) witnessed the finding and removed the pudding from the cart. On 8/20/25 at 12:15 PM, another leftover pudding was found inside the medication Cart #2 of Wye Oak Unit, also dated 8/19 for 7-3 shift. CMA #38 was informed and removed the bowl from the cart. On 8/20/2025 at 12:48 PM, the DON was notified of the findings and stated that staff education would be provided. 4) Per Centers for Disease Control (CDC), Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 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 (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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). On 8/20/2025 at 9:09 AM, a review of Resident #12's wound evaluation dated 8/5/25 confirmed the presence of a Stage 3 Pressure ulcer of the sacrum which was acquired on 1/1/25. On 8/21/2025 at 7:06 AM, an observation of Resident #12's room showed no EBP sign or PPE cart outside the room. On 8/21/2025 at 7:57 AM, in an interview with Licensed Practical Nurse #16, he/she stated that an EBP was utilized for residents who have external catheters, wounds and tube feedings. He/she added that the staff are expected to wear PPE when giving direct care. On 8/21/2025 at 8:58 AM, LPN #26 stated that EBP is indicated for protection from infection. He/she stated that it is used for residents with dialysis access and intravenous(IV) site. On 8/21/2025 at 10:43 AM, in an interview with the Infection Control Preventionist (ICP) and Staff Educator, she revealed that EBP was used for residents with wounds, foley catheter, IV and drains. She stated that the nurses were expected to enter the EBP orders in the medical record and ensure that the EBP signs and PPE carts were placed in a timely manner. She added that she conducted rounds and audits. The ICP Nurse was informed of the concerns and stated that she will ensure that an EBP sign and PPE cart would be placed for Resident #12. On 8/25/2025 at 10:30 AM, a review of Resident #12's medical record revealed no evidence of an EBP order. However, the facility's EBP policy revised on 3/26/24 stated that An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds such as pressure ulcer. On 8/26/2025 at 7:43 AM, the DON confirmed the absence of the EBP order in the medical record and acknowledged this concern. She indicated that staff in-service training on this matter would be provided. 5. During a Medical Record review on 8/25/25 at 8:35 AM it was discovered that Resident #116 was being treated for a Stage 3 Pressure Ulcer and had no order for Enhanced Barrier Precautions (EBP). During an observation of the room for Resident #116 on 8/28/25 at 2:22 PM it was discovered that there was no Enhanced Barrier Precaution sign or EBP supplies near the resident's room. During an interview with Unit Manager #4 on 8/28/25 at 3:07 PM she confirmed that Resident #116 had a pressure ulcer but didn't believe it was severe enough to require EBP and reported she would find out. During an observation of the room for Resident #116 on 9/02/25 at 9:00 AM it was discovered there was now an Enhanced Barrier Precautions sign and EBP supplies at the resident's doorway. During a medical record review on 9/02/25 at 9:37 AM it was discovered that there was an order placed on 8/28/25 at 4:31 PM for EBP that stated, Enhanced Barrier Precautions: Everyone must wear gloves and a gown for the following High-Contact resident care activities: Dressing, Bathing/showering/transferring, changing linens, Providing Hygiene, changing briefs or assisting with toileting. Wound Care: Any skin opening requiring a dressing. (continued on next page)

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

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Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Director of Nursing (DON) on 9/02/25 at 11:06 AM she advised that all Residents with a pressure ulcer should be on EBP no matter how severe. She confirmed that Resident #116 should have been on EBP. She reported the Infection Preventionist is looking into ensuring EBP is implemented when it's required. During a review of the Enhanced Barrier Precautions Policy 9/02/25 at 1:48 PM it stated that An order for enhanced barrier precautions will be obtained for Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers). The policy continued with Implementation of Enhanced Barrier Precautions: Make gowns and gloves available immediately near or outside of the resident's room and ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room.) During a follow up interview with the Unit Manager on 9/02/25 at 3:02 PM she reported that Resident #116 should have been on EBP due to having a pressure ulcer and reported anyone that has a wound that is staged gets an isolation bin for EBP.

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

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation and interviews, it was determined that the facility failed to ensure there was an effective pest control program for the kitchen. This was evident during the survey of the kitchen. This deficiency has the potential to affect all residents.The findings include: On 08/19/2025 at 06:32 AM, this surveyor conducted an interview with the Dietary Manager regarding pest concerns in the kitchen. She reported that the primary issue observed in the kitchen was the presence of flies.On 08/29/2025 at 10:51 AM, this surveyor observed five flies that were flying above the food preparation area where Dietary [NAME] #44 was preparing crab cakes for the residents. On 08/29/2025 at 10:58 AM, this surveyor informed the part-time Dietary Director of the concerns regarding the flies. He confirmed his understanding of the issue.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations and interview it was determined that the facility failed to ensure Residents were provided a dignified existence. This was evident for 14 (Resident #116, #84, #12, #91, #107, #57, #36, #14, #31, #21, #61, #115, #155 & #40) out of 38 Residents observed for dining during the recertification survey.The findings include: 1. During an interview with Resident #116 in his/her room on 8/19/25 at 1:58 PM a rapid knock occurred on the closed door, the door immediately opened and Geriatric Nursing Assistant (GNA) #3 entered the room. She yelled out, It's me and continued to the roommates (Resident #84) side of the room. Resident #84 was not in the room at this time. When Resident #116 was asked who the GNA was that entered the room he/she reported they had seen her before but didn't remember her name. During an interview with GNA #3 on 8/19/25 at 2:13 PM she reported that she went to the roommate's side of the room to get something for Resident #84. She said she should have identified herself when entering the room of Resident #116. During an interview with the Director of Nursing on 9/02/25 at 11:14 AM she reported that the expectations are for staff to provide residents with privacy. Staff members should introduce themselves when they enter a resident's room and ask if it's okay to come in. During a review of the facility's Resident Rights Policy on 9/02/25 at 2:22 PM it was revealed that the Resident has a right to personal privacy and includes accommodations, medical treatment, written and telephone communications, personal care, visits. 2. During an observation of Resident #116 on 8/28/25 at 2:23 PM he/she was seen sitting near the nursing station in a wheelchair. He/she asked Geriatric Nursing Assistant (GNA) #45 Can you take me to my room? I've got to pee bad! GNA didn't respond and walked around the backside of the resident. Resident #116 then yelled, I've got to go! GNA #45 then told the resident to hold on. Resident #116 asked, How can I hold on? and appeared anxious. GNA #45 walked down a separate hallway. During an observation of Resident #116 on 8/28/25 at 2:28 PM he/she started yelling for someone to take him/her to their room stating, I really have to go! During an observation of Resident #116 on 8/28/25 at 2:32 PM he/she was yelling for help to return to his/her room. GNA #45 returned, she didn't say anything to Resident #116, she got behind him/her and started pushing them to their room. During an observation of Resident #116 on 8/28/25 at 2:34 PM resident is in his/her room with GNA #45 and was unable to find a urine receptacle. Registered Nurse (RN) #13 entered the room to assist. During an observation of Resident #116 on 8/28/25 at 2:36 PM the resident was anxious and still waiting for a urine receptacle. The resident was yelling Hurry please! GNA #45 had left the room and was seen walking unhurriedly by the nursing station. RN #13 remained with the resident. During an observation of Resident #116 on 8/28/25 at 2:39 PM RN #13 told the resident that they were out of urine receptacles on the unit, so GNA #45 went to get one. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident #116 on 8/28/25 at 2:40 PM he/she was anxious and yelling, I've got to go bad! RN #13 offered him/her to use the commode and Resident #116 reported, No, I can't use that! During an observation of Resident #116 on 8/28/25 at 2:41 PM resident was anxious, Where did she go to get that thing? I need it! Where did she go to get it? RN #13 told him/her Central Supply and reported she will go see what was going on. RN #13 left the room. During an observation of Resident #116 on 8/28/25 at 2:44 PM the resident rolled out of his/her room in a wheelchair. The resident appeared anxious, breathing heavily and holding his/her groin area. Resident #116 was looking down the hallway for assistance. RN #13 was seen coming toward the Resident's room with a urine receptacle. During an interview with RN #13 on 08/28/2025 at 2:52 PM she reported she had asked GNA #45 to get a urine receptacle from central supply and it was taking so long, so she went to go get it. She reported the GNA told her she had to go check on her residents. RN #13 advised she didn't know why the resident didn't already have a urine receptacle. During an interview with GNA #45 on 8/28/25 at 2:54 PM she reported she wasn't looking for a urine receptacle, she stated she had to go check on my people and advised I didn't have him/her today when referring to Resident #116. During an interview with Unit Manager #4 on 8/28/25 at 3:07 PM she reported it is expected that assistance be provided to all residents. It was unacceptable to state that it's not my resident. All of us are here to help all residents. 3. Resident Requiring Assistance with Feeding - A resident who is unable to independently consume meals and requires staff assistance for the physical act of eating, which may include hand-over-hand guidance, cutting or preparing food into manageable portions, or direct feeding. This assistance is provided to ensure the resident receives adequate nutrition and hydration in accordance with their individualized care plan. On 08/28/2025 at 12:21 PM, this surveyor observed the distribution of lunch to residents on the Homestead Unit. At 12:29 PM, Resident #84 was observed seated at a table with other residents. Resident #84 did not have a meal tray in front of them, while all other residents at the table were actively eating. On 08/28/2025 at 12:31 PM, this surveyor interviewed Geriatric Nursing Assistant (GNA) #28 regarding the absence of a tray for Resident #84. GNA #28 reported that Resident #84 is a feeder, requiring staff assistance with eating. She explained that she had been instructed to ensure all trays were distributed to other residents before beginning to serve and assist residents who require help with feeding, as staff were expected to focus first on tray distribution. This surveyor expressed concern that Resident #84 was left without a meal while observing other residents eat, which represented a potential dignity issue. Based on observation and interview, it was determined that the facility failed to protect and value the resident's private space by failing to knock prior to entering a resident's room. This was evident for 1 (Resident #12) of 13 residents reviewed for dignity during the recertification survey. (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 8/19/2025 at 9:18 AM, while the surveyor was interviewing Resident #12, Geriatric Nurse Assistant (GNA #17) abruptly opened the resident's door without knocking. He/she stated the need to collect the breakfast trays. Resident #12 confirmed that staff frequently enter their room without knocking. On 8/27/2025 at 9:46 AM, in an interview with Licensed Practical Nurse (LPN #18), he/she stated that the staff were expected to knock and introduce themselves prior to entering residents' room. On 8/27/2025 at 9:56 AM, the Director of Nursing (DON) was informed of this concern and acknowledged the issue. 5) During an observation on 08/24/25 at 12:04 PM this Surveyor observed the lunch meal cart arrive at the Homestead nursing unit. The staff were observed delivering lunch trays to Residents in the dining room and Resident rooms. During the lunch service Residents #91, #107, #57, #36, #14, #31, #21, #61, #115 & #155 were observed sitting at tables in the dining room watching other residents eat their lunch. The residents who received their lunch trays ate their food and their trays were removed by staff and placed back on to the meal cart. Residents #91, #107, #57, #36, #14, #31, #21, #61, #115 & #155 remained seated at the dining room tables still waiting to be served their lunch. During an interview conducted on 08/24/25 at 12:47 PM, Registered Nurse (RN) #13 confirmed that there is a delay between meal carts which resulted in several Residents not receiving their meals with all the other Residents on the Homestead Nursing Unit. During an interview conducted on 08/24/25 at 1:00 PM this Surveyor discussed with the Nursing Home Administrator (NHA) the dignity concern for the Residents who had not received their lunch with all the other Residents. These Residents had to watch the other Residents eat their meal while waiting for over an hour to receive their meal. The NHA stated that she would investigate the delay. The NHA quickly returned and stated the second meal cart is entering the nursing unit now at 1:05 PM. This Surveyor expressed the concern that there was an one hour delay between the meal services. This Surveyor observed the second meal cart arrive at the unit at 1:05 PM. Staff retrieved the meal trays and delivered the trays to Residents #91, #107, #57, #36, #14, #31, #21, #61, #115, & #155. 6) During an interview with the Resident Council conducted on 08/28/25 at 3:00 PM, the Resident Council members unanimously stated that they had been restricted from using the public restrooms located off of the lobby of the facility. During an interview with the NHA conducted on 09/02/25 at approximately 8:30 AM, the NHA stated that the public bathrooms located off of the lobby were for the visitors and staff only. She stated that when the Residents had access to the public bathrooms the bathrooms would become dirty. Therefore, she restricted the Residents from using the public bathrooms. 7) During the initial tour of the facility conducted on 08/19/25 at 6:12 AM, this Surveyor observed Geriatric Nursing Assistant (GNA) #24 without a name badge. When asked if she had a name badge she stated yes. This Surveyor observed the GNA reach into her purse, retrieved her name badge and placed it on her uniform. When asked what the policy was for name badges the GNA replied we are expected to always wear our name badge. (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a random observation of the Homestead Nursing Unit conducted on 08/24/25 at 11:47 AM, this Surveyor observed GNA #12 without a name badge. When asked if he had a name badge the GNA responded yes, it is in my car. The GNA returned approximately 10 minutes later and showed this Surveyor his badge. The GNA apologized and stated he knows he should have been wearing his name badge. During another random observation conducted on 08/24/25 at 12:43 PM, this Surveyor observed GNA #12 inside of Resident room # 315 on his personal cell phone. The GNA ended his call and exited the room. When asked if using a personal cell phone allowed, the GNA responded no but he needed to check on something. 8. On 08/20/2025 at 8:13 AM observed Resident #40 in bed receiving G-tube feeding. observed oral secretions drooling from his/her mouth onto his/her gown. The resident's oral cavity was noted to be poorly maintained, with dry yellowish mucous build-up on the tongue. On 08/20/2025 at 8:20 AM observed in bed with dry yellowish mucous and secretions noted on his/her gown, particularly on the left side of the chest. 08/20/2025 9:00 AM observed resident lying in bed on his/her left side, with poor hygiene. Oral secretions were noted drooling from his/her mouth while the G-tube feeding was running. 08/20/2025 10:00 AM observed resident lying in the same position with build-up dry yellowish mucous on the tongue and drooling secretions on the left side of the chest. 08/20/2025 10:03 AM the surveyor called the Director of Nursing (DON) to Resident #40's room and asked about the expectation for the resident's care. The DON stated that the resident required mouth care. When asked how often staff are expected to provide mouth care, the DON stated, Every shift. When asked about the expectation for turning and repositioning, the DON stated that residents are to be turned and repositioned every two hours. The surveyor brought the above concerns to the DON's attention, and she acknowledged receipt, stating, I am going to educate the staff. On 08/24/2025 at 1:05 PM, during rounds in room [ROOM NUMBER], the surveyor observed Resident #40 lying in bed with his/her mouth open. Dry, thick yellowish mucous was noted in her mouth, and her lower lip appeared dry. Licensed Practical Nurse (LPN) #14 and Registered Nurse (RN) #20 were present, confirmed the observation, and acknowledged receipt of the concern. On 08/24/2025 at 1:15 PM, the surveyor informed the Administrator of the concern regarding Resident #40's oral condition. The Administrator stated, Yes, it was brought to my attention on Friday by the DON. I will follow up.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and interviews, it was determined that the facility failed to ensure the residents and the residents' representatives were offered the opportunity to develop an advanced directive. This was evident for 4 (Residents #12, #8, #3 and #40) of 7 residents reviewed for advanced directives during the recertification survey. The findings include: 1. An Advance Directive is a legal document in which a person specifies their wishes regarding medical treatment in situations where they may no longer be able to express informed consent. It can include instructions about end-of-life care and may appoint a healthcare proxy (someone to make medical decisions on their behalf). A BIMS assessment is the Brief Interview for Mental Status, a short screening tool used in long-term care to quickly identify changes in a resident's cognitive function. On 8/20/2025 at 7:17 AM, a review of Resident #12's medical record and paper chart revealed no evidence that an advanced directive was documented on file. Further review of the resident's medical record showed a BIMS (Brief Interview for Mental Status) score was 14, which indicated he/she was cognitively intact. Additionally, a Peak Social Services Assessment Tool dated 9/13/22, did not indicate that the resident was offered to formulate an advanced directive. On 8/20/2025 at 8:44 AM, a review of Resident #8's medical record also showed no advanced directive on file. The resident's BIMS score was 5, which indicated he/she was cognitively impaired. On 8/21/2025 at 1:14 PM, the Regional Social Worker confirmed that Residents #8 and #12 along with their families, were not offered the opportunity to formulate an advanced directive. On 8/26/2025 at 7:43 AM, the Director of Nursing (DON) was informed of this concern. 2. On 08/27/2025 at 9:15 AM review of medical records revealed that written information regarding advance directives had not been provided to Residents #3 and #40 or their representatives, and the information was not present at the time of review. During an interview with the Regional Social Worker (RSW) on 08/27/2025 at 9:46 AM, she explained that during the admission process, residents are asked if they have an advance directive. If they do, a copy is requested; if not, they are offered the opportunity to complete one. Completed assessments are documented in Point Click Care (PCC) under Key Social Service Assessment. She stated that if the assessment is not documented in PCC, the form was not offered to the resident. On 08/27/2025 at 10:00 AM, the Regional Social Worker confirmed that the families of Residents #3 and #40 were not offered or educated on advance directives during the admission process. On 08/27/2025 at 10:30 AM, the surveyor informed the Regional Social Worker that, according to Federal regulation, facilities are required to offer written information on advance directives to all residents at the time of admission. The surveyor made her aware of the concern, and she acknowledged receipt.

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
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility failed to provide a clean, safe and homelike environment. This was found to be evident during multiple tours and random observations of the facility during the recertification survey. The findings include: During the initial tour of the facility conducted on 08/19/2025 at 6:00 AM, the carpets throughout the entire facility had multiple large stains. In Resident rooms #117 and #205 there were large black markings and a sticky substance on the white tile floors that caused Surveyors' shoes to stick to the floor when they walked in the rooms. During a tour of the Homestead Nursing unit conducted on 08/19/25 at 6:23 AM, this Surveyor shoes were sticking to the white tiled floors as he/she entered the nursing unit. The white tiled flooring had a sticky substance and black markings throughout. In Resident room [ROOM NUMBER] there were large black markings and a sticky substance on the floor throughout the entire room. The sticky substance and black markings led from the hallway and into the Resident room. The sticky substance caused this Surveyor shoes to stick to the floor as he/she walked from the hallway and into Resident room [ROOM NUMBER]. During a random tour of the Homestead nursing unit conducted on 08/24/25 at approximately 11:45 AM, this Surveyor smelled a strong urine smell coming from Resident room [ROOM NUMBER]. During an interview conducted on 08/24/25 at 11:47 AM, this Surveyor and Registered Nurse (RN) #13 went to Resident room [ROOM NUMBER]. The RN checked Resident #84, and Resident #116 disposable diapers and determined both Residents' diapers were dry. The RN stated that the strong urine smell was coming for the floor and trash can. She further stated that she had not seen housekeeping all day but would contact housekeeping to clean the floors and remove the trash. During a follow up observation of Resident room [ROOM NUMBER] conducted on 08/24/25 at 1:30 PM, this surveyor observed housekeeping exit the room. Observation of the room confirmed the resident room no longer had a strong smell of urine. During an interview conducted on 09/04/25 at approximately 6:35 AM, in discussing the flooring the NHA stated that she would contact corporate for an update on the facility's flooring. The NHA returned on 09/04/25 at approximately 11:45 AM and provided a purchase order for a [NAME] Commercial Big [NAME] Carpet Extractor that had a create date of 07/25/25. The NHA also provided follow-up emails from corporate that inquired about the status of the carpet cleaner on 08/28/25. The email stated Any word on when we can be expecting this?? States in building and asking about floor cleaning.

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	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

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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. 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. (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
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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

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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 - 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. 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. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews and record reviews it was determined the facility failed to ensure Resident Care Plans were developed. This was found to be evident for 4 (Resident #92, #107, #12 and #8) out of 23 Residents reviewed for Care Plans during the recertification survey. The findings include: 1. During an interview conducted on 08/19/2025 at 12:17 PM, Resident #92 reported that he/she does not participate in activities because of a vision deficit. When asked if one-on-one activities were provided the Resident responded no. A care plan is a formal, personalized, written document outlining a patient's specific medical, functional, and psychosocial needs, and the services and support required to address them. Developed through a comprehensive assessment by an interdisciplinary team, these plans guide care, foster communication among providers, involve the patient and their family, and track progress to help individuals achieve their health goals. A review of Resident 92's Care Plan was conducted on 08/19/25 at 12:20 PM. The review did not reveal a Care Plan for Activities. 2. During a telephone interview conducted on 08/19/25 at 1:19 PM, Resident #107's Representative reported that the Resident was cognitively impaired and did not participate in Activities. The Representative stated that the Activities department had not offered the Resident any services such as one- to-one visits or anything else. The Representative further reported that the Resident was incontinent for bowel and bladder as was concerned that the Resident was not receiving routine incontinent care. A Minimum Data Set (MDS) is a federally mandated standardized clinical assessment for residents in Medicare and Medicaid-certified nursing homes. It's a core set of data elements covering residents' health, functional, and cognitive status to identify problems, form individual care plans, and facilitate communication across the care continuum. Nursing home staff conduct MDS assessments upon admission, periodically, and on discharge. A review of Resident #107's MDS section H Bladder and Bowel dated 08/13/25 conducted on 08/19/25 at 1:22 PM showed that the Resident was always incontinent for urine and frequently incontinent for bowel A review of Resident #107's Care Plan was conducted on 08/19/25 at 1:29 PM. The review did not reveal a Care Plan for Activities or Bowel Incontinence. During an interview conducted on 08/28/25 at 8:07 AM the Activities Director confirmed that Activity Care Plans had not been developed by the previous Activities Director for Resident #92 and #107. She further stated that she would begin developing Care Plans for each Resident. During an interview conducted on 09/04/25 at approximately 9:45 AM, the MDS Coordinator reviewed Resident #107's Care Plan and acknowledged that a Bowel Incontinence Care Plan had not been developed. She stated that she would develop the Care Plan. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS coordinator returned on 09/04/25 at approximately 10:00 AM and provided this Surveyor with an Incontinence Bowel Care Plan for Resident #107. 3. On 8/20/2025 at 9:09 AM, a review of Resident #12's wound evaluation dated 8/5/25, confirmed the presence of a Stage 3 Pressure ulcer of the sacrum, which was acquired on 1/1/25. On 8/21/2025 at 7:06 AM, an observation of Resident #12's room showed no EBP sign or PPE cart outside the room. On 8/21/2025 at 10:43 AM, in an interview with the Infection Control Preventionist (ICP) and Staff Educator, she revealed that EBP was used for residents with wounds, Foley catheter, intravenous (IVs) and drains. She stated that the nurses were expected to enter the EBP orders in the medical record and update the care plan. On 8/25/2025 at 10:44 AM, a review of Resident #12's care plan did not show any evidence that an EBP care plan was initiated for the presence of pressure ulcer. On 8/26/2025 at 7:43AM, in an interview with the Director of Nursing (DON), she stated that nurses were expected to initiate the residents' care plan upon admission. The Unit Managers then check the care plans and perform necessary corrections/ updates when needed. The DON was asked to verify the Foley catheter care plan of Resident #8 as well as the EBP care plan of Resident #12. She confirmed that there was none. The DON acknowledged this concern and stated that staff education will be provided. 4. A foley catheter is a flexible tube inserted into the bladder to continuously drain urine into a collection bag. Per Centers for Disease Control (CDC), EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBPs involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). On 8/20/2025 at 4:46 PM, a review of Resident #8's pertinent physician orders confirmed that he/she was on a Foley catheter from 6/4/25 to 8/4/25. On 8/20/2025 at 7:04 PM, a review of Resident #8's care plan revealed no evidence that a Foley catheter care plan was initiated since 6/4/25. On 8/26/2025 at 8:49 AM, a review of the Quarterly MDS assessment with an Assessment Reference Data (ARD) of 7/26/25, also confirmed the use of an indwelling catheter.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews it was determined the facility failed to 1) have quarterly care plan meeting with the interdisciplinary team. This was found to be evident for 1 (Resident #116) out of 22 residents reviewed for Care Plan Meetings, 2) review and revise the care plans to meet resident's needs, This was evident for (Resident #8, #12 and #107) of 23 residents reviewed for care plan timing and revision during the recertification survey. 3) develop a comprehensive care plan within the required timeframe. This was evident for 1 (#11) of 23 residents reviewed for pressure injuries during the recertification survey.The findings include: 1. Care plan meetings are meetings with a team of care providers including the attending physician, a registered nurse with responsibility for the resident, a nursing assistant with responsibility for the resident, a member of food and nutrition services, the resident, and the resident's representative if applicable to ensure the care plan is continually adjusted to meet the changing needs or concerns of residents. Care plan meetings are required to be held quarterly. During an interview with Resident #116 on 8/19/25 at 1:56 PM he/she reported having care plan meetings on occasions but couldn't recall the last time one was held. During a review of medical records for Resident #116 on 8/19/25 at 6:23 PM it was discovered that he/she had a care plan meeting in 2025 and was it held on 5/07/25. Resident #116 only had two care plan meetings in 2024, and they were held on 4/25/24 and 10/11/24. During an interview with the Regional Social Worker on 8/26/25 at 11:17 AM she reported Social Work, Nursing, dietary and a Geriatric Nursing Assistant would attend the Care Plan meeting, and the meetings were to be completed quarterly. She advised the care plan meeting documentation would be found in the Resident's Electronic Medical Records. During an interview with the Regional Social Worker on 8/26/25 at 1:53 PM she reported she had found an additional care plan meeting for Resident #116 that hadn't been uploaded into the Electronic Medical Records yet and it was held on 8/05/25. She confirmed there were no other Quarterly Care Plan meetings held for Resident #116 in 2024 or 2025. She reported she was unsure of the reason the other care plan meetings were not held because she was not at the facility at that time. 2. According to CMS (Centers for Medicare and Medicaid Services), in long-term care facilities, care plans should be reviewed and updated at least every 90 days, or more frequently if a resident's condition changes significantly. On 8/26/2025 at 7:22 AM, a review of Resident #8's care plan, initiated on May 8, 2025, indicated non-compliance with smoking/vaping policies. On 8/26/2025 at 7:59 AM, the Minimum Data Set (MDS) Coordinator confirmed that resident care plans were expected to be updated following quarterly or comprehensive care plan meetings. On 8/27/2025 at 8:18 AM, the Director of Nursing (DON) stated that a care plan was developed after Resident #8 was found with a vape in her room. The DON confirmed no prior reports of Resident #8 smoking in the facility and stated that care plans are updated quarterly and upon changes in condition. (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She also confirmed that the smoking/vaping care plan for Resident #8 should have been resolved. 3) On 8/28/2025 at 7:07 AM, a review of Resident #12's fall care plan which stated, Resident is at risk for falls related to history of fall and generalized weakness, was initiated on 09/10/22. However, the most recent revision was on 2/23/24. On 8/29/2025 at 8:19 AM, the MDS coordinator confirmed that the last update was in 2024 and stated that the care plan should have been updated quarterly. On 9/03/2025 at 7:30 AM, the DON was notified that Resident #12's fall care plan has not been updated for 16 months. 4. During a telephone interview conducted on 08/19/2025 at 1:29 PM Resident #107's Representative stated that the Resident had multiple falls that resulted in hip and arm fractures. During a review of Resident #107's change in condition forms conducted on 8/28/2025 at 2:11 PM revealed that the Resident fell on [DATE], 05/22/24, 09/04/24, 03/08/25, 03/11/25, 03/31/25, and 05/09/25. A care plan is a formal, personalized, written document outlining a patient's specific medical, functional, and psychosocial needs, and the services and support required to address them. Developed through a comprehensive assessment by an interdisciplinary team, these plans guide care, foster communication among providers, involve the patient and their family, and track progress to help individuals achieve their health goals. A review of the Resident's Care Plan conducted on 08/28/25 at 2:20 PM did not show that the Care Plan was revised to include the actual fall on 05/09/25. During an interview conducted on 08/28/25 at approximately 2:50 PM, the MDS Coordinator reviewed the Care Plan with this Surveyor and confirmed that the Care Plan was not revised to include the actual fall on 05/09/25. 5. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Review of Resident #11's clinical record on 08/25/25 revealed that s/he was readmitted to the facility on [DATE] from the hospital after surgical treatment for a pressure injury. Review of Resident #11's admission MDS assessment, completed on 7/26/25, indicated the presence of one or more unhealed pressure injuries (Section M0210). Further review of Resident #11's comprehensive care plan on 08/25/25 at 9:30 AM revealed no evidence of interventions or approaches to address the resident's pressure injury. On 8/27/25, a subsequent review of Resident #11's clinical record was conducted. The review revealed that a pressure injury care plan was initiated on 8/27/2025 by the MDS Coordinator. This was 32 days after the admission MDS completion date. (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/3/25 at 10:07 AM, the Director of Nursing (DON) confirmed that the care plan for Resident #11's pressure injury was not initiated until 8/27/2025.

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record reviews, interviews and observations it was determined that the facility failed to ensure medical records were accurate, complete and readily assessible. This was found to be evident for 3 (Resident #92, #116 and #84) out of 3 Residents reviewed for accurate, complete and readily accessible medical records during the recertification survey. The findings include: 1. During a review of Resident #92's Medication Administration Record (MAR) for August 2025 conducted on 09/02/25 at 7:30 AM, the following order was discovered weigh every morning after void and before breakfast call provider with the weight gain of more that 3 pounds an 1 day one time a day for monitoring call provider for weight gain more than 3 pounds in 24 hrs (hours) start date 07/13/25 0630. Further review of the Resident's MAR showed it had a column for each day of the month and a box under the day for the nursing staff to initial. However, there was no place to document the actual weight. A review of the Resident #92's medical record conducted on 09/02/25 at 7:41 AM showed weights under the vital signs section. There were 2 weights documented one on 07/14/25 and another on 08/09/25. During an interview conducted on 09/02/25 at approximately 9:45 AM, this Surveyor and Nursing Home Administrator (NHA) reviewed Resident #92's MAR and the weights in the section for vital signs. The NHA acknowledged that the Resident weights should have been recorded. This Surveyor expressed concern that the staff would not be able to determine if the Resident had a 3-pound weight gain in 24 hours because they currently would not know what the Resident weighed the prior day. The NHA stated that she understood. Based on medical record reviews, interviews and observations it was determined that the facility failed to ensure medical records were complete, readily assessable and organized. This was evident for 2 (Resident #116 and #84) of 2 residents reviewed for medical records. 2. Occult blood refers to microscopic amounts of blood that are not visible to the naked eye but can be detected through laboratory tests During a review of medical records for Resident #116 on 8/19/25 at 5:50 PM it was revealed that the Nurse Practitioner (NP) wrote progress notes that reported an order had not been completed. A note written on 5/29/24 stated, waiting on stool for occult blood. Will likely need GI consult. A note written on 7/02/24 reported, Stool for occult blood was ordered back in May but has not been performed and discussed need for stool for occult blood with nursing staff. Per staff, they have had difficulty obtaining stool sample. A note written on 12/13/24 reported, stool for occult blood was ordered several months ago, but this was never completed. Consider GI referral. During a continued medical record review for Resident #116 it was discovered that the order for stool (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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for occult blood every night shift was checked off as completed in the Treatment Administration Record (TAR) on the following dates, May 23, 24, 25, 29, 30 of 2024 June 3, 4, 5, 6, 7, 10, 11, 12, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29 of 2024 July 1, 2, 4, 8, 13 of 2024 During an interview with the Director of Nursing (DON) on 8/25/25 at 11:19 AM she advised she didn't know why the specimen was not obtained because she was not with the facility at that time. She reported that the order should not have been signed off in the TAR if it was not completed. 3. During a review of medical records for Resident #116 on 8/19/25 at 6:22 PM it was discovered that on 8/05/25 an order was placed for a Specialty Air Mattress in place at all times for protection and preventative measures. During an observation of the bed for Resident #116 on 8/20/25 at 7:46 AM it was discovered that the resident was not lying on an air mattress. During a repeat observation of the bed for Resident #116 with Registered Nurse #13 on 8/21/25 at 8:33 AM she confirmed the resident did not have an air mattress but should have one on his/her bed. 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 didn't have one at this time. She reported maintenance advised all the air mattresses had been utilized and additional ones were ordered. During a review of the Task Administration Record (TAR) on 8/21/25 at 2:17 PM it was revealed that the order for Resident #116 to have an air mattress was signed off as completed from the evening shift on August 6, 2025 through August 21, 2025, day shift. During an observation of the bed for Resident #116 on 8/25/25 at 10:48 AM it was discovered that there is now an Air mattress on the resident's bed. During an interview with the DON on 8/25/25 at 11:19 AM she advised the order for an air mattress should not have been signed off in the TAR if Resident #116 didn't have an air mattress. 4. A Medication Regimen Review (MRR) is a systematic and comprehensive evaluation of a resident's current and historical medication use to identify and resolve potential drug-related problems and optimize medication therapy. During a review of medical records for Resident #84 on 8/19/25 at 6:26 PM it was revealed that the Pharmacist had performed a Medication Regimen Review (MRR) and had made recommendations on 6/10/25. The MRR advised to See Report for the recommendations. The Report was not found in the resident's Electronic Medical Records (EMR). During a review of medical records for Resident #116 on 8/19/25 at 6:28 PM it was revealed that the Pharmacist had performed a MRR and had made recommendations on 3/04/25, 4/08/25 and 8/12/25. The MRR document advised to See Report for the recommendations. The reports were not found in (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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Resident's Electronic Medical Records. During an interview with the Director of Nursing (DON) on 8/28/25 at 7:33 AM she reported that the MRR reports are scanned into the resident's electronic medical record (EMR). She said she was currently working on the MRR reports from August but would expect the MRR reports from previous months to be in the EMR. During an interview with the MDS Coordinator on 8/28/25 at 8:17 AM she reported she is not sure why the MRR reports hadn't been loaded into the Resident's EMR for Resident #116 and Resident #84. She reported that since she returned to the facility she has been assisting the DON put the MRR reports into the EMR. During an interview with the MDS Coordinator on 8/28/25 at 10:12 AM she provided the MRR reports requested for Resident #84 and #116. She confirmed they had not yet been downloaded into the EMR for the residents.

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

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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

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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. 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. (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

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interview and record review, it was determined that the facility failed to invite the resident to participate in the care planning process. This was evident for 1 (Resident #8) of 5 residents reviewed for care planning during the recertification survey.The findings include:According to CMS (Centers for Medicare and Medicaid Services), a care plan meeting is a structured, interdisciplinary conference where staff, residents, and families discuss and review the resident's care plan, ensuring needs are met and goals are achievedOn 8/20/2025 at 7:56 AM, Resident #8 stated he/she had never been invited to any care plan meetings. On 8/20/2025 at 4:46 PM, a review of Resident #8's clinical record revealed a BIMS (Brief Interview for Mental Status) score of 5 which indicated severe impairment. On 8/21/2025 at 1:20 PM, in an interview with Social Worker Assistant, she confirmed that care plan meeting invitations were typically verbal, sent via email or were hand-delivered. On 8/26/2025 at 11:17 AM, the Regional Social Worker (SW) stated that a care plan meeting form was utilized to document concerns and verified the attendance by the Interdisciplinary Team (IDT), family and resident. These meetings were held quarterly. On 8/26/2025 at 1:50 PM, a paper copy of the Care Plan Conference summary dated 4/1/25 was received from the Regional SW. It indicated that the meeting was attended by the SW Assistant, Nursing staff and the resident's family member via phone. However, no evidence showed that Resident #8 was invited. On 8/27/2025 at 10:10 AM, the Regional SW confirmed that she has not attempted to invite Resident #8 to any care plan meetings, believing the resident was not capable. The surveyor informed the Regional SW of this concern. On 8/27/2025 at 10:20 AM, in a telephone interview with Resident #8's family member, he/she expressed that his/her sibling should be invited and confirmed that the facility has never invited his/her sibling to any of the care plan meetings. On 8/29/2025 at 7:28 AM, a review of the care plan meeting notes from 8/27/25 at 2:30 PM, revealed that Resident #8 was still not invited. On 9/03/2025 at 7:30 AM, the Director of Nursing (DON) was informed of this concern and acknowledged it.

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, it was determined that the facility failed to provide the right to self-determination. This was found evident in 1 (Resident #121) out of 1 Resident reviewed for Self-Determination. The findings include:On 08/19/2025 at 11:56 AM, this surveyor conducted an interview with Resident #121. During this interview, he/she reported being unsure why he/she was placed on the secluded Homestead Unit. On 08/19/2025 at 2:46 PM, this surveyor conducted an interview with the Director of Nursing (DON). During this interview, the DON was informed of concerns that Resident #121 did not know why he/she was placed on the Homestead Unit, which is a locked/secured unit. The DON stated that this was her fourth week of employment at the facility and acknowledged that she was not yet familiar with this Resident. She confirmed that she could not provide information as to why Resident #121 had been placed on the Homestead Unit. The DON reported that she would speak with the Resident and consider the possibility of relocating him/her to another room on a different unit.On 08/20/2025 at 8:23 AM, this surveyor conducted an interview with Resident #121 in his/her room on the Homestead Unit. Resident #121 reported that he/she believed he/she was being moved that morning to the Chesapeake Unit. He/she stated that he/she was very excited about the move. On 08/20/2025 at 9:59 AM, this surveyor conducted an interview with the Administrator regarding Resident #121's original placement on the Homestead Unit. The Administrator reported that Resident #121's BIMS score was high, and he/she did not meet the requirements for placement on the Homestead Unit. She stated that at the time, the Chesapeake Unit had limited availability, and Resident #121 had mentioned prior experience living with residents with dementia. Therefore, Resident #121 was asked if he/she was interested in being placed on the Homestead Unit, and he/she agreed at that time.On 08/20/2025 at 11:56 AM, this surveyor conducted interview with staff on the Homestead Unit, Licensed Practical Nurse (LPN) #1, confirmed that the residents on the Homestead Unit were ever given the code to leave the Homestead unit. On 08/20/2025 at 12:00 PM, this surveyor interviewed Unit Manager #4 regarding the Homestead Unit and Resident #121. The Unit Manager confirmed that residents do not have access to exit the locked unit and can only leave when accompanied by staff. Resident #121 was reported to have no behaviors. When asked why the resident was placed on the Homestead Unit, the Unit Manager initially suggested a dementia and schizophrenia diagnosis; however, chart review completed by the Unit Manager during the interview did not confirm dementia. She further explained that residents are typically placed on the Homestead Unit for dementia, behaviors, history of elopement, trauma, or wandering, but she was unaware of Resident #121 having any of these. Ultimately, the Unit Manager was unsure why Resident #121 was returned to the Homestead Unit and confirmed that the resident exhibits no behaviors.On 08/20/2025 at 12:17 PM, this surveyor interviewed Resident #121 in the dining hall outside of the locked Homestead Unit. The resident appeared pleasant and expressed appreciation for no longer being on the Homestead Unit. When asked if they had ever been given the code to leave the unit independently, the resident confirmed they had not.On 08/20/2025 at 1:56 PM, this surveyor reviewed Resident #121's record and found no documentation of a wandering or elopement assessment/evaluation. On 08/25/2025 at 08:30 AM, another record review of Resident #121's chart revealed that this resident does not have a diagnosis with Dementia, and according to the MDS assessment, no behaviors were exhibited and no behaviors of wandering were exhibited. On 08/26/2025 at 10:50AM, this surveyor conducted an interview with the Regional Social Work Director, she reported that she had officially starting working for the facility in March. When asked how is it that a Resident is determined to be placed on the Homestead Unit, she reported that it is for safety reasons. She reported that it is a process where an IDT gets together and when they have noticed that a resident is wandering or exit seeking, if they have behaviors, that is when they determine a resident should be placed on the homestead unit. She also explained if the resident is having behaviors such a disturbing other (continued on next page)

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

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Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. She reported that the IDT that discusses whether a resident should be placed on the Homestead Unit consists usually of Social work, nursing, the unit managers, and administrator. It was then asked if she was aware of Resident #121, and if she was aware why this Resident was transferred to the Homestead Unit? She reported that she knows that she was transferred there but does not know the reason why. On 08/26/2025 at 11:35 AM, this surveyor conducted an interview with the Administrator regarding the process for placing residents on the Homestead Unit. She reported that placement decisions are based on information gathered from nursing staff or from direct observations of resident behaviors. Residents may be placed on the unit if they demonstrate wandering, significant behavioral issues (such as frequent screaming), or have a dementia diagnosis.The Administrator stated that placement decisions are typically made by the Interdisciplinary Team (IDT), which includes the Director of Nursing, Unit Manager, Administrator, Social Worker, and Admissions Coordinator. However, she acknowledged that the process is not standardized and varies person to person, noting that sometimes residents are placed on the unit at the request of families.When asked if there was a formal protocol or official criteria for determining placement on the Homestead Unit, she reported that there is not, and that placement is dependent on individual circumstances. She confirmed that once residents are placed on the unit, they cannot leave freely, meaning they do not have access to the code required to exit the unit. She further confirmed that it is not regular practice for residents to be reassessed to determine whether placement on the locked unit remains appropriate.At this time, the surveyor asked if the Administrator could provide documentation or reasoning for why Resident #121 was placed on the Homestead Unit. She stated that she would look into the matter and get back to the surveyor.On 08/29/2025 at 10:04 AM, this surveyor conducted an interview with the Administrator, who confirmed that there was no documentation explaining why Resident #121 was originally placed on the Homestead Unit.On 09/02/2025 at 11:43 PM, this surveyor conducted a follow-up interview with the Administrator. She again confirmed that she could not locate any documentation explaining why Resident #121 was placed on the Homestead Unit. At this time, the Administrator was made aware that the survey team would be bringing forward concerns regarding Resident #121's placement on the Homestead Unit without documented justification.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review it was determined that the facility failed to 1) provide a private meeting for the Resident Council, 2) address grievances in a timely manner for 6 (Resident# 81, #44, #92, #12, #66, and #54) out of 12 Residents, and 3) provide grievance feedback. This was found to be evident for 1 out 1 observation of the Resident Council Meeting (RCM) during the recertification survey.The findings include: 1)During an interview conducted on 08/27/25 at approximately 11:30 AM, the Nursing Home Administrator (NHA) advised this Surveyor that the Resident Council Meeting would be held in the Main Dining Room or another room on 08/28/25 at 2:00 PM. During an interview conducted on 08/28/25 at 9:19 AM, Resident #54 invited this Surveyor to attend the Resident Council Meeting on 08/28/25 at 2:00 PM in the Main Dining Room. During an observation of the Resident Council Meeting (RCM) conducted on 8/28/2025 at 2:00 PM, it was discovered that the Main Dining Room was located off the lobby. The room was open to the public and provided no privacy to the Resident Council Meeting. All staff and visitors must pass by the Main Dining Room when going to and from the lobby and when entering or exiting the facility. Across from the Main Dining Room were two business offices where staff and residents visited. The Main Dining Room was observed to have 2 open-to-air doorway spaces and 3 open-to-air window spaces along with an entry door to the kitchen. While the meeting was being conducted staff were observed walking in and out of the Main Dining Room. During an interview conducted 08/28/25 at 3:37 PM, this Surveyor asked the Resident Council members how often the Resident Council had met in the Main Dining Room. The Residents unanimously replied that the Main Dining Room had been the only place the facility had allowed the Resident Council to meet. The Residents voiced their concern for not being allowed to have privacy during their meetings. When asked if the members are allowed to meet without staff the members stated no.During an interview conducted on 09/02/25 at approximately 9:00 AM, this Surveyor asked the Nursing Home Administrator (NHA) how long the Resident Council Meetings had been held in the Main Dining Room. The NHA stated that since she had been at the facility (a little more than a year) all the Resident Council Meetings had been held in the Main Dining Room. This Surveyor discussed the concern for the lack of privacy and asked why the facility had not made arrangements to ensure the Resident Council had privacy during their meetings. The NHA stated the she would like to be fully transparent and stated that she did not have a reason. She stated going forward the Resident Council will meet monthly in the [NAME] Great Room which was announced at the Resident Council Meeting on 08/28/25. During a continued interview this Surveyor expressed concern that the Resident Council members unanimously stated that they are not allowed to hold a meeting without staff. The NHA acknowledged that it was true because the members are incapable of taking meeting minutes. Therefore, a staff member must be in attendance to take the meeting minutes. This Surveyor advised the NHA the Resident Council has a right to meet without staff. 2) During a review of the Resident Council Meeting Minutes conducted on 09/02/25 at 10:30 AM, it was discovered that laundry concerns had been discussed since December 2024 however the facility failed to address the grievance until the Resident Council Meeting this Surveyor attended on 08/28/25. During the Resident Council Meeting conducted on 08/28/25 at 2:00 PM Resident #81reported 4 pairs of jeans and a green sweater missing. Resident #44 reported 1 pair of jeans and a night gown with lace straps missing. Resident #92 reported 1 missing pillowcase that has the blessed mother's prayer on it. Resident #12 reported 1 pair of red gym shorts, I pair of cutoff sweatpants, 1 pair of long pants, gray coat, 12 pair of socks, 1 blanket, 5 tshirts (fruit of the loom), and 1 gray sweatshirt with a hood. Resident #66 reported missing 1 pair of [NAME] jeans and 2 or 3 white tshirts. Resident # 54 reported missing 5 pair of sweatpants: 1 camo, 2 black and 2 blue. The Activities Director was observed documenting each missing item for reach Resident on a form. 3) During an interview with the members of the Resident Council on 08/28/25 at approximately 3:25 PM, (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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the members stated that their grievances discussed in the meeting go unresolved. When asked if the facility provided a rationale as to why the grievance could not be resolved, the members unanimously stated no. A further review of the meeting minutes did not show the grievances discussed in the meetings from 09/24 through 7/25 were fully addressed and resolutions provided to the Resident Council. During an interview conducted on 09/02/25 at approximately 9:10 AM, this Surveyor asked the NHA why the laundry concerns and other grievances had not been addressed and communicated to the Resident Council. The NHA stated that the previous Activity Director failed to disseminate the concerns to each department and therefore the grievances went unaddressed. She stated going forward the new Activity Director would ensure the grievance would be addressed.

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

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on observation, interviews and record review it was determined that the facility failed to ensure Residents were notified of all the Resident [NAME] of Rights. This was found to be evident during the Resident Council meeting during the recertification survey.The findings include: A Nursing Home Resident's [NAME] of Rights ensures residents are treated with dignity, receive quality care, and are free from abuse, neglect, or restraint. Mandated by the federal Nursing Home Reform Act of 1987, it includes rights like the right to participate in care decisions, privacy, access to information, the ability to voice complaints without fear, and the freedom to make independent choices about daily life and activities.During an interview with the members/residents of the Resident Council meeting conducted on 8/28/25 at 3:37 PM, the members/residents were asked if they were informed of the Resident [NAME] of Rights. The group of members/residents unanimously replied no. The Activities Director, who was in attendance, advised the Resident Council members that she would begin to verbally inform the members/residents of 3 Resident [NAME] of Rights during each meeting going forward starting with the meeting that was presently being held. This Surveyor observed the Activities Director informing the Resident Council members/residents of the Resident [NAME] of Rights on 08/28/25 at 3:55 PM.During an interview conducted on 09/02/25 at approximately 9:00 AM, this Surveyor asked the Nursing Home Administrator (NHA) how Residents are informed of the Resident [NAME] of Rights. The NHA replied that she believed they are provided in the admission Packet. During a review of the admission Packet conducted on 09/02/25 at 9:12 AM, this Surveyor reported to the NHA that the admission Packet stated that some of those rights are listed When asked if the residents were given a complete list and description of the Resident [NAME] of Rights the NHA reported that she held an annual Resident [NAME] Rights fair with the Residents in September. The NHA reported that she provided a list and verbally informed the Residents of each of the Resident [NAME] of Rights during the fair. When asked how Residents that had not attended the fair receive the Resident [NAME] of Rights the NHA replied she believed they are included in the admission Packet. The Surveyor expressed concern that the admission Packet only provided some of the Resident [NAME] of Rights and the complete list was only provided during the annual Resident [NAME] of Rights fair. Residents who were not in the facility at the time or admitted after the fair were not given a complete list or informed of all the Resident [NAME] of Rights.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview, it was determined that the facility failed to provide adequate privacy to the resident by exposing their body parts. This was evident for 1 (Resident #42) of 1 resident sampled during the medication administration.The findings include: On 8/21/2025 at 8:28 AM, during the medication administration, Resident #42 was observed in bed with their blanket pulled below the knee and gown above the abdomen, exposing their thighs and brief. The privacy curtain and door were wide open, making the resident's body parts visible to visitors and staff. On 8/21/2025 at 8:31 AM, the surveyor informed Certified Medication Aide (CMA #10) of this concern. CMA #10 acknowledged and stated that the privacy curtain should have been pulled during the medication administration. On 8/26/2025 at 7:43 AM, the Director of Nursing (DON) was informed of this concern.

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

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Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews and a review of pertinent documentation it was determined that the facility failed to ensure grievances were addressed in a timely manner. This was found to be evident for 1 (Resident #122) out of 1 Resident reviewed for grievances during the recertification survey.The findings include: During an interview conducted on 09/02/25 at 5:30 PM, Resident #122's family member stated that he/she is having issues getting the Resident clothes returned when taken to the facility's laundry to be cleaned. Because the clothes are not returned the Resident is forced to wear the same clothes until some of the clothes are returned. This has been an ongoing problem. The family member further stated that when he/she asked staff about the missing clothes he/she was told that they were short-handed, or a washer broke down. We recently spent close to $300.00 to replace the missing clothes and hangers only just to have them again never to return. The family member also reported that a sibling put name tags on every item: pants, tops, nightgowns, etc. During an interview conducted on 09/03/25 at approximately 7:40 am the Director of Nursing (DON) explained the facility's policy for missing items: when items are reported missing, staff notify the laundry department to look for them. Residents and/or family members are expected to complete an inventory sheet as part of the admission paperwork. The DON and Surveyor reviewed Resident #122's inventory list and verified that the family completed an inventory sheet, which listed a few items but did not include clothing. She further explained that families often bring in additional clothing after admission without updating the inventory sheet. The DON stated that when a family reports missing items, they are instructed to complete a grievance form, which is then forwarded to the appropriate department for follow-up. On 09/03/2025 at 8:35 AM an interview was conducted with the Nursing Home Administrator (NHA). The Administrator stated that the process for missing clothing is for staff to notify the laundry department to search for the items. If the items are not found, the facility provides a grievance form. Once the grievance form is completed, the facility instructs the family or resident to purchase replacement items and submit receipts for reimbursement. The Administrator confirmed that grievance forms were not accessible on the Wye Oak and Mill Landing nursing units. When asked if she had received any grievances from Resident #122's family member the NHA stated that she recalled speaking with the family member sometime last year regarding the resident's roommate and concerns about bathing, but she was not aware of missing clothing. The Administrator confirmed that a meeting was held with the IDT and the family on 07/22/2025 during which time missing items were discussed; however, no grievance form was completed. She acknowledged receipt of the concerns and stated that the process was not followed.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined that the facility failed to ensure 1) a Resident received a bed hold notice and 2) the Ombudsman was notified of transfers and discharges. This was found to be evident for 1 (Resident #107) out of 1 Resident reviewed for hospitalization during the recertification survey.The findings include:1) During a telephone interview conducted on 08/19/2025 at 1:29 PM Resident #107's Representative stated that the Resident was recently hospitalized . A review of Resident #107's medical record conducted on 09/01/2025 at 5:26 PM showed that the Resident was transferred to a local hospital on [DATE] and returned same day.During an interview with the Nursing Home Administrator (NHA) conducted on 09/02/25 at approximately 7:49 AM, this Surveyor requested the bed hold notification for the past 6 months.During an interview conducted on 09/04/25 at approximately 10:00 AM, the Regional Social worker advised that the facility provided bed hold notification to Residents who had been transferred out of the facility for more than 24 hours. In the case of Resident #107, the Resident or Representative was not provided with a bed hold notice because the Resident returned to the facility the same day. This Surveyor expressed concern for the lack of notification.A review of the facility's Transfer and Discharge (including AMA) policy conducted 09/04/25 at 10:05 AM Section 12 Emergency Transfer/Discharges: subsection g. stated Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated. The policy did not refer to a time frame of how long the resident is out of the facility before the bed hold would be issued.2) During an interview with Ombudsman conducted on 08/28/25 at 1:19 PM, The Ombudsman reported that she had not been notified in writing of Resident transfers and discharges.During an interview with the Nursing Home Administrator (NHA) conducted on 09/02/25 at approximately 7:49 AM, this Surveyor requested the Ombudsman notification list for the month of May and June 2025.The NHA returned on 09/02/25 at approximately 10:50 AM and provided the Ombudsman notification list. During the review of the Ombudsman list, it was discovered that the lists for May and June 2025 were emailed to the Ombudsman on 09/02/25 at 10:32 AM after this Surveyor requested the lists.During an interview with the NHA conducted on 09/02/25 at approximately 10:52 AM, this Surveyor expressed concern that the list for May and June 2025 were emailed 3 months late to the Ombudsman. The Surveyor also expressed concern that the lists were emailed after the Surveyor made the request. The NHA responded that she understood.

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review and interview, it was determined that the facility failed to complete an admission MDS (Minimum Data Set) assessment within the required timeframe. This was evident for 1 (Resident #102) of 1 resident reviewed for resident assessments during the recertification survey.The findings include:Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. According to Centers for Medicare and Medicaid Services Resident Assessment Instrument's (CMS RAI) Version 3.0 manual, nursing homes are required to submit an Omnibus Budget Reconciliation Act (OBRA) required MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the payer source. On 8/25/2025 at 7:50 AM, a review of Resident #102's medical record showed an admission or entry date of 8/1/25. According to CMS's RAI manual, For the admission assessment, the MDS Completion date (Z0500B) must be no later than 13 days after the Entry date (A1600) and the Care Area Assessment (CAA) Completion date (V0200B2) must be no later than 13 days after the Entry Date (A1600). However, Resident #102's admission MDS with an Assessment Reference Date (ARD) of 8/7/25 was still labeled as In progress and revealed that sections Z0500B and V0200B2 were not signed within the required 13-day timeframe. On 8/25/2025 at 8:56 AM, in an interview with the MDS coordinator, she expressed uncertainty about the 14-day timeline for completing and submitting MDS assessments. She confirmed completing and signing section Z0400 and stated that the Corporate MDS reviewed her work, signed sections V0200C2 and Z0500B and transmitted the completed assessments to the national database. On 8/25/25 at 12:39 PM, the Administrator in Training (AIT #1) provided the surveyor with a copy of Resident #102's MDS sections V and Z which supported these findings. On 8/26/2025 at 8:08 AM, in a follow-up interview with the MDS coordinator, she confirmed that she completed section Z0400 on 8/11/25 and acknowledged that Resident #102's admission MDS assessment should have been signed within 13 days of 8/1/25. On 8/26/2025 at 8:43 AM, the Director of Nursing (DON) was informed of this concern.

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, it was determined that the facility failed to transmit a Minimum Data Set (MDS) assessment within 14 days of completion. This was evident for 1 (Resident #102) of 1 resident reviewed for resident assessments during the recertification survey. The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. Nursing homes are required to submit the Omnibus Budget Reconciliation Act (OBRA) required MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the payer source to Centers for Medicare and Medicaid Services (CMS') Internet Quality Improvement and Evaluation System (iQIES). Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. On 8/25/2025 at 7:50 AM, a review of Resident #102's medical record showed an admission or entry date of 8/1/25. An Entry MDS assessment with an Assessment Reference Date (ARD) of 8/1/25 was labeled exported, which meant that the facility has prepared the assessment to be transmitted to the national database managed by the CMS, however, the assessment was not submitted within the required 14- day timeframe.The Entry assessment was transmitted on 8/25/25 following surveyor intervention. On 8/25/2025 at 8:56 AM, in an interview with the MDS coordinator, she expressed uncertainty about the 14-day timeline for completing and submitting MDS assessments. She confirmed completing the Entry MDS and stated that the Corporate MDS reviewed her work and transmitted completed MDS assessments. On 8/26/2025 at 8:08 AM, in a follow-up interview with the MDS coordinator, she confirmed completing section Z0400 on 8/5/25 and acknowledged that Resident #102's Entry MDS assessment should have been transmitted within 14 days. On 8/26/2025 at 8:43 AM, the Director of Nursing (DON) was informed of this concern.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to accurately code and assess the Minimum Data Set (MDS) assessment. This was evident for 2 (Resident #8 and #13) of 2 residents reviewed during the recertification survey. The findings include: 1. Minimum Data Set (MDS) is a federally mandated comprehensive clinical assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. A foley catheter is a flexible tube inserted into the bladder to continuously drain urine into a collection bag. On 8/20/2025 at 4:46 PM, a review of Resident #8's pertinent physician orders confirmed that he/she was on Foley catheter from 6/4/25 to 8/4/25. On 8/26/2025 at 8:49 AM, a review of the Quarterly MDS assessment with an Assessment Reference Data (ARD) of 7/26/25 revealed that Item H0100 Appliances: Indwelling catheter (including suprapubic catheter and nephrostomy tube) was coded YES, however item H0300 Urinary Continence was coded 3. always incontinent. The Coding instructions from the MDS Resident Assessment Instrument (RAI) manual are as follows: Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime. Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime. Code 3, always incontinent: if during the 7-day look-back period, the resident had no continent voids. Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days. On 8/26/2025 at 9:35 AM, during an interview with the MDS nurse, she confirmed that the urinary continence of Resident #8 was inaccurately coded and should have been coded to 9, not rated. On 8/26/2025 at 9:44 AM, the surveyor received a copy of the assessment modification which reflected the corrected not rated status for urinary incontinence. On 8/27/2025 at 9:56 AM, the Director of Nursing (DON) was informed and acknowledged this concern. (continued on next page)

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	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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Discharge assessments include items for quality monitoring. Discharge assessment reporting is required for all residents in the nursing home who have been physically discharged from the facility. A record review for Resident #13 on 08/29/2025 at 7:10 AM showed that the Resident was admitted to the facility on [DATE]. The continued review contained a nurse's note dated 8/12/2025 stated that Resident #13 was discharged from the facility to the hospital. Further review of Resident #13's MDS record showed a lack of discharge assessment for the Resident. In an interview on 08/29/2025 at 8:50AM the MDS Coordinator confirmed that the facility failed to complete discharge assessments for Resident #13. Further record review on 09/02/2025 at 10:00 AM revealed that, following the surveyor's intervention on 08/29/2025, an MDS assessment for discharge return anticipation was initiated on 08/29/2025.

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	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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record reviews, and staff interviews, it was determined that the facility failed to: 1) follow physician orders for turning and repositioning, 2) ensure physician orders were obtained for hospice or end-of-life care and 3) ensure the provision of sufficient supply of linens for residents. This was evident for 2 residents (#40 and #3) out of 2 residents reviewed for quality of care during the recertification and complaint survey process.The findings include: The process of regularly changing a resident's body position to reduce pressure on bony prominences, improve circulation, prevent skin breakdown (pressure injuries), and maintain comfort. This includes moving residents in bed, adjusting their position in a chair, or assisting them to sit or lie in a different position, typically on a scheduled basis (e.g., every 2 hours). 1) During rounds on the Chesapeake Unit, the surveyor observed Resident #40 on 08/20/2025 at 6:30 AM, 8:30 AM, and 10:30 AM, and on 08/21/2025 at 8:15 AM and 10:15 AM, lying in bed on his/her left side without evidence of repositioning. On 08/20/2025 at 10:40 AM, the surveyor interviewed LPN #14 regarding the expectation for residents with limited bed mobility. She stated that residents are to be turned and repositioned every two hours. The surveyor made her aware of the observed concerns, and she acknowledged receipt. On 08/20/2025 at 11:03 AM, the surveyor called the Director of Nursing (DON) to Resident #40's room, where the resident was observed lying on his/her left side. The DON confirmed the observation. On 08/20/2025 at 12:05PM record review revealed physician orders for Resident #40 to be turned and repositioned every two hours and as needed. Further review of record on 08/20/2025 at 5:21 PM revealed physician orders for Resident #40's Treatment Administration Record (TAR) from August 1 through August 20, 2025, indicated staff had signed the treatment as completed. On 08/21/2025 at 8:05 AM, the surveyor interviewed the Director of Nursing (DON) regarding turning and repositioning for residents with limited bed mobility. The DON stated that residents are to be turned and repositioned every two hours and as needed. The surveyor informed her of the observed concerns, and she acknowledged receipt, stating, I am going to educate the staff. On 08/21/2025 at 2:07 PM, following the surveyor's intervention, the Director of Nursing (DON) informed the surveyor that staff had received education on turning and repositioning. She also reported that staff were provided with pillows to assist in positioning residents properly in bed. 2. Hospice care service is a coordinated approach to support terminally ill patients by focusing on comfort, symptom management, and quality of life, rather than curing the illness, while also providing emotional and practical support to their families. During medical record review on 08/21/2025 at 7:23 AM, it was revealed that resident #3 was admitted to [NAME] Hospice care on 07/01/2025; however, no physician orders were found at the time of review. (continued on next page)

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

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Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of medical records on 08/25/2025 at 12:30 PM revealed a physician's order stating: Hospice Services: [NAME] initiated 08/25/2025 following the surveyor's intervention On 08/27/2025 at 11:59 AM, during an interview with the DON regarding expectations for residents admitted to hospice, she stated that the expectation is for the physician to write orders as soon as the resident is admitted . The surveyor made her aware of the above concern, and she acknowledged receipt. 3. On 08/25/2025 at 1:25 PM, this surveyor conducted an interview with Geriatric Nursing Assistant (GNA) #2, who works on the Homestead Unit. She reported ongoing issues with linens within the facility, stating that on 08/19/2025, the unit only had 10 towels available for use during the day shift. There were approximately 44 Residents that currently resided on this unit. On 08/27/2025 at approximately 10:00 AM, this surveyor conducted an interview with GNA #3, also assigned to the Homestead Unit. She confirmed that there are persistent laundry issues and reported that there is usually not enough available linen to make beds or provide towels for residents. On 09/02/2025 at 4:02 PM, this surveyor conducted an interview with Registered Nurse (RN) #13. When asked about linen availability, RN #13 reported that there are not enough linens and stated that this shortage sometimes results in beds being observed without sheet covers. On 09/03/2025, this surveyor conducted multiple observations and interviews related to bed linens for residents. 10:18 AM: Resident #29's bed was not made; it had no cover sheet, pillowcases, or blanket. 10:21 AM: Resident #31's bed was not made; mattress was bare with no sheets. 10:47 AM: Resident #32's bed was not made; mattress had no sheets. 10:58 AM: Resident #108's bed was made but had no blanket. 10:58 AM: Resident #86 was lying on a bare mattress with no sheets or blanket. 10:59 AM: An interview with Resident #86 revealed he/she requested a fitted bed sheet. 11:26 AM: Resident #100's bed was not made; mattress had no sheets. During an interview, Resident #100 reported that the sheets had been removed that morning after breakfast and that he/she was waiting for someone to make the bed. 11:50 AM: Resident #34's bed was not made; no sheets or pillowcases were present. Resident interviews confirmed that some residents were aware of the lack of linens and were actively waiting for sheets to be provided. Observations and interviews indicate that multiple residents' beds were not properly made and lacked essential linens, which may impact resident care and comfort. On 09/03/2025 at 2:24 PM, this surveyor conducted an interview with the Maintenance Director regarding linens and inventory. The Maintenance Director reported that the facility is currently operating past its linen needs. He stated that a large order for linens was placed the previous week; (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	however, he noted that insufficient linen availability is a consistent issue within the facility. When asked about barriers to meeting linen needs, he identified budget constraints. He explained that nursing communicates linen needs, typically during morning meetings, and that he is informed when additional linens are required. The Maintenance Director confirmed that the Administrator is aware of these concerns and is copied on emails he sends to the corporate office regarding linen requests. On 09/04/2025 at 12:55 PM, this surveyor conducted an interview with the Administrator regarding linen availability. The Administrator was asked if she was aware of any current lack of linens. She reported that she was not aware and that the Maintenance Director orders linens on a weekly basis. When asked how long complaints about insufficient linens had been occurring, she stated that issues were first noted in March, as brought up during a different survey. She was asked what actions were taken after March to address linen needs, and she reported that additional supplies were ordered. The Administrator stated that she was not aware of the specific budget for linen supplies. The surveyor made the Administrator aware of observations and interviews indicating that there was a lack of sufficient linens for residents within the facility at this time, and that this concern was being brought back to the office.

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	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

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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. **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 (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
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 - apply zinc oxide paste to base of wound, leave open to air and change daily.Right gluteal fold pressure ulcer/injury - Cleanse with normal saline, apply calcium alginate to base of the wound, secure with bordered foam and change daily.Left gluteal fold pressure ulcer/injury - Cleanse with normal saline, apply calcium alginate to base of the wound, secure with bordered foam and change daily.Right heel pressure ulcer/injury - apply skin prep to base of wound, leave open to air and apply twice a dayLeft buttock pressure ulcer/injury - Zinc oxide paste to base of the wound, leave open to air, apply twice a day.The Wound Care Provider also recommended an alternating air/low air loss mattress for pressure redistribution.Further medical record review of the orders for Resident #131 showed that no wound care orders were placed for the pressure ulcers/injuries until 3/06/25. The wound care orders that were initially placed included:Order placed on 3/06/25 stated Left and Right buttock: skin prep every shift for wound healing Order placed on 3/06/25 stated Left and Right Gluteal fold: Cleanse with wound cleanser, apply calcium alginate/medihoney and cover with bordered foam everyday shift for wound healing.Order placed on 3/06/25 stated Right heel: skin prep: everyday shift for wound healing.Order placed on 3/13/25 stated Air mattress to bed, check functioning each shift. During an interview with the Director of Nursing (DON) on 9/02/25 at 10:52 AM she reported Wound Care Providers would see new residents admitted with a wound on a weekly basis and would be expected to be seen within a week at the latest. She advised Wound Care Providers send their recommendations after seeing the resident via e-mail within 24 hours to the facility. The doctor would then approve the orders and then the MDS Coordinator would put the wound care orders into the resident's EMR. She confirmed that there was no evidence of wound care being completed prior to the orders being placed into the EMR for Resident #131. She reported she was not with the facility at the time that the resident was here so she was not sure what the delay was for the resident to receive wound care, see Wound Care Providers or for the Wound care orders to be placed into the EMR. During a review of the Pressure Injury Prevention and Management policy on 9/02/25 at 2:46 PM it was discovered that Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. During a review of the Documentation of Wound Treatments Policy on 9/02/25 at 2:48 PM it was revealed that Wound Assessments are documented upon admission, weekly and as needed if the resident or wound condition deteriorates and Wound treatments are documented at the time of each treatment. If no treatment is due, an indication on the status of the dressing shall be documented each shift. (i.e., clean, dry, intact).During an interview with the MDS Coordinator on 9/04/25 at 11:16 AM she agreed there was a delay in Resident #131 getting wound care and having wound care orders added into the EMR. She reported that she was not at the facility at the time that the resident was in the facility, so she is not sure what may have caused the delays. She reported that when she returned to the facility she recognized an issue with wound care orders not being added into the EMR, so she offered to help to ensure the orders were being placed in a timely manner.

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

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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. Based on record reviews, observations and interviews it was determined that the facility failed to implement an intervention, determined to be necessary, for a resident who was identified as a fall risk. This was evident for 1 (Resident #84) of 6 residents reviewed for accidents during the recertification survey. The findings include: During a phone interview with the family member of Resident #84 on 8/19/25 at 2:52 PM he/she reported that the facility called today because Resident #84 rolled out of bed and fell to the floor. The family member reported that the resident had a history of rolling out of his/her bed. During a medical record review for Resident #84 on 08/20/2025 at 11:41 AM it was discovered that the resident had fallen on 8/19/25 and found near his/her bed lying on stomach wrapped in blankets. The Resident did not have any injuries and the family was notified at 10:35 AM. A perimeter mattress has a raised, padded edge, or perimeter, that prevents residents from accidentally falling out of bed During an additional review of Change in Condition Evaluation reports it was revealed that Resident #84 had falls on 3/18/25, 4/02/25 where he/she was found on right side of bed and on 5/11/25 where he/she was found laying beside his/her bed. After the fall on 5/11/25 the resident's care plan was updated with fall prevention interventions to be taken for the resident which included a Perimeter mattress to bed. During an observation on 8/20/25 at 7:46 AM it was discovered that Resident #84 did not have a perimeter mattress on his/her bed. During an observation with Registered Nurse (RN) #13 on 8/21/25 at 8:06 AM she confirmed that Resident #84 did not have a perimeter mattress on his/her bed. She reported Resident #84 had recently moved to his/her current room from another unit, so I'll check with them, it may be over there.During an additional review of the medical records for Resident #84 on 8/21/25 at 8:27 AM it was revealed he/she transferred from his/her previous room on 8/15/25.During an interview with Unit Manager #4 on 8/21/25 at 1:06 PM she reported that Resident #84 did have a perimeter bed in his/her previous room but when they transferred rooms only the resident was brought, not the perimeter mattress. She confirmed that Resident #84 should have the perimeter mattress on his/her bed.During an interview with the Maintenance Director on 8/21/25 at 1:47 PM he reported a request was submitted for a Perimeter mattress on 8/21/25 at 1:25 PM by Unit Manager #4 for Resident #84, the request stated, Need a perimeter mattress on ASAP. During an interview with the Director of Nursing (DON) on 8/21/25 at 2:08 PM she reported that Resident #84 was attempting to roll and then rolled off the bed when he/she fell on 8/19/25. She agreed that Resident #84 should have had the perimeter mattress on his/her bed. The mattress was left behind when the resident was moved from his/her previous room. The DON reported she plans on putting in place, a procedure to ensure the room is checked for specialty equipment when the resident is transferred. During an observation of the bed for Resident #84 on 8/25/25 at 8:00 AM it was discovered that his/her bed now has a perimeter mattress.

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on medical record review, observation, and interviews with facility staff, it was determined that the facility staff failed to consult the resident's physician to clarify orders regarding the medication route, G-tube feeding residual parameters, and ensuring the resident received feedings as ordered. This was evident for 1 resident (#40) out of 1 resident reviewed during the recertification survey process. On 08/25/2025 at 10:22 AM, review of Resident #40's medical record revealed the following physician orders: Thiamine HCl Oral Tablet 100 mg: Give 1 tablet by mouth once daily for supplementation, ordered on 05/10/2025 and Melatonin Oral Tablet 3 mg, give 1 tablet by mouth at bedtime for insomnia, ordered on 05/09/2025.On 08/25/2025 at 1:30 AM, further review of Resident #40's medical record revealed a physician's order for diet texture: Nothing by Mouth (NPO). Check residual: hold feeding x1 hour if residual is >___cc and recheck every shift. During rounds on 08/21/2025 at 10:00 AM, the surveyor observed Resident #40's G-tube feeding bag hanging on the pump and connected to the resident. The feeding bag was dated 08/19/2025; however, the pump was not infusing at the time of the observation. On 08/21/2025 at 10:15 AM, the surveyor called LPN #14 to Resident #40's room. LPN #14 confirmed that the feeding bottle had not been changed and stated, the 11-7 AM shift did not give report that the pump was not working. She further explained that there was no physician order to hold the feeding. On 08/21/2025 at 10:13 AM, during an interview with the Director of Nursing (DON) regarding the expectation for residents receiving G-tube feedings and following physician's orders, the DON confirmed that Resident #40 is NPO and that all medications must be administered via the G-tube. She further stated that the expectation is for feeding bottles to be changed daily with the date and time documented. The surveyor made DON aware of the above concerns, and she acknowledged receipt.On 09/04/2025 at 11:59 AM interview with the MDS Coordinator (covering for the DON) was conducted regarding orders for residuals to hold feedings Resident #40, She confirmed that the orders did not include parameters for holding the feeding. The surveyor informed her of the concern, and she acknowledged the concern and stated, I will take care of it right now. On 09/04/2025 at 12:12 PM following the surveyor's intervention, the MDS Coordinator reported and submitted a copy of a physician's order dated 09/04/2025. The order stated: Check residual; call provider for hold if residual >30cc, as needed for tube feedings and every shift.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 maintain respiratory equipment in a sanitary manner for 3 (Resident #26, #118 and #69) out of 3 residents observed for respiratory care. The findings include: A nasal cannula is a device that gives you additional oxygen through your nose. It's a thin, flexible tube that goes around your head and into your nose. There are two prongs that go inside your nostrils that deliver the oxygen. A nebulizer is a medical device that converts liquid medication into a fine mist, allowing the resident to inhale it through their nose or mouth. 1. During an observation on 8/20/25 at 12:12 PM it was observed that Resident #26 was on oxygen and there was no sign for oxygen in use at the doorway. Further observation revealed the resident was receiving oxygen via a nasal cannula. The nasal cannula was not dated or labeled. Resident #26 also had a portable oxygen bottle with a nasal cannula connected to the bottle on his/her wheelchair. The tubing and the end with the nasal prongs was lying on the floor of the resident's room. The tubing on the portable oxygen bottle was also was not dated or labeled. There was also a used nebulizer on his/her bedside table that was not bagged or covered. During an interview with Resident #26 on 8/20/25 at 12:12 PM the resident reported he/she doesn't think the nasal cannula had been changed since arriving at the facility. During an observation of the room for Resident #26 with Registered Nurse (RN) #20 on 8/20/25 at 12:14 PM he reported the nasal cannula should not be lying on the floor and should be discarded. He advised the nebulizer should be in a zip locked bag and not laying out uncovered. He stated the nasal cannulas should be changed weekly and advised there would be an order for oxygen tubing to be changed every Tuesday in the Task Administration Record (TAR). He reported there was no oxygen sign on the door because, we didn't have a sign. During an observation of RN #20 on 8/20/25 at 12:33 PM he was observed replacing the nebulizer for Resident #26 and placed an oxygen in use sign outside of the resident's doorway. During a review of the medical records for Resident #26 on 8/20/25 at 12:34 PM it was discovered that he/she was admitted on [DATE] and was on oxygen since being admitted . There were no orders found for changing or maintaining the oxygen supplies for Resident #26. During an additional interview with RN #20 on 8/20/25 at 12:37 PM he confirmed the nasal cannula changes were not listed in the TAR and advised he had to put the orders into the resident's Electronic Medical Record (EMR). During an interview with the Director of Nursing (DON) on 8/20/25 at 1:03 PM she reported there should be an order for the oxygen tubing to be changed and labeled once a week. She added nebulizers need to be in a bag and dated. During a chart review on 8/21/25 at 7:31 AM it was discovered the following order was added to the chart for Resident #26 on 8/20/25. Change Oxygen tubing and humidification bottle every Tuesday (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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	night – label with date, shift and initials. During a review of the Oxygen Administration Policy it on 8/21/25 at 1:32 PM it revealed that Infection control measures include: Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated and keep delivery devices covered in plastic bag when not in use. The policy also stated Oxygen warning signs must be placed on the door of the Resident's room where oxygen is in use 2. During an observation of the room for Resident #118 on 8/27/25 at 12:11 PM a used nebulizer attached to a mask and tubing was seen sitting on the bedside stand. The nebulizer was not labeled or in a bag. The Resident was not in his/her room. During a medical record review on 8/27/25 at 12:14 PM it was discovered that Resident #118 had an order that stated, change nebulizer mask and tubing weekly; date and place in a dated plastic bag. During an observation with Licensed Practical Nurse (LPN) #26 on 8/27/25 at 12:22 PM he reported that the nebulizer should be dated and stored in a bag. He put an unlabeled bag on the bedside table and reported that would be the bag used to store the nebulizer. He confirmed the bag was not dated. During an additional observation on 8/27/25 at 12:30 PM, the unlabeled bag remained on the bedside table and the uncovered nebulizer had been placed in the holder provided on the machine During a review of the Oxygen Administration Policy it stated to keep delivery devices covered in plastic bag when not in use. 3. Oxygen therapy is a treatment that provides a person with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider. On 8/21/2025 at 8:05 AM, Resident #69 was observed using a portable oxygen tank via nasal cannula. The oxygen tubing was noted unlabeled. Licensed Practical Nurse (LPN #16) was notified of this concern and acknowledged the need for labeling. On 8/27/2025 at 9:46 AM, during an interview with LPN #18, he/she stated that nurses were expected to ensure that tubing were labeled and stored in bags when not in use. He/she also mentioned that tubing was changed every Tuesday during 11-7 shift. On 8/27/2025 at 9:56 AM, in an interview with the Director of Nursing (DON), she confirmed that when caring for residents on 02 therapy, nurses were expected that oxygen tubing were labeled. The DON also noted that she had been informed of a similar concern by another surveyor and had already initiated an in-service training and implemented a plan to address this issue.

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

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observations and interviews it was determined that the facility failed to ensure staff postings were updated. This was found to be evident for 4 out of 4 staff assignment boards and 1 facility staff posting observed during the recertification survey.The findings include: During the initial tour of the nursing units conducted on 08/19/2025 from 6:04 AM through 6:20 AM this surveyor observed the assignment board for Mill Landing, Wye Oak, and Chesapeake. Each board was dated for 08/18/25 shift 7-3 with the staff assignment by room number, ratio, unit manager, and census. A review of the assignment books also showed that the staffing sheet for each nursing unit had not been completed since 08/17/25.During an interview conducted on 08/19/25 between 6:06 AM and 6:22 AM, License Practical Nurse (LPN) #21, Registered Nurse (RN) # 20, and LPN #23 confirmed that the assignment boards had not been updated and reported that the facility's expectation is to update the board at the beginning of each shift. During a continued tour conducted on 08/19/25 at 6:25 AM, this Surveyor observed the assignment board on the Homestead dated 08/17/22 for the shift 7am -3pm with the staff assignment by room number, ratio, unit manager and census. During an interview conducted on 08/19/25 at 6:44 AM, RN #22 advised the board should had been updated for each day and each shift from 08/17/25. On 08/25/25 at 1:37 PM this Surveyor observed staff posting dated 08/22/25 located on a table located at the front entrance door of the lobby. During an interview conducted on 08/25/25 at approximately 1:42 PM, the Nursing Home Administrator (NHA) confirmed that the posting located on the table in the lobby by the front entrance door was dated 08/22/25 and should have been updated to reflect the correct date, staffing assignment and census.

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interview, it was determined that the facility failed to act on the consultant pharmacist's medication regimen review (MRR) recommendations in a timely manner. This was evident for 1 (#7) of 5 residents reviewed for unnecessary medications during the annual survey.The findings include: On 9/3/25 at 9:48 AM, this surveyor requested Resident #7's medication regimen reviews for June, July, and August 2025. The facility provided the June and August MRRs, which the surveyor reviewed on 9/3/25 at 11:15 AM. The July 2025 MRR was not provided. At approximately 12:17 PM on 9/3/25, this surveyor made a second request to the DON for the July 2025 MRR. At 1:34 PM, the Rehab Director provided this surveyor a handwritten note from the DON which stated, July med recs faxed to NP and currently is working on them.In an interview on 9/3/25 at 2:24 PM, the DON confirmed that Resident #7's July 2025 MRR had been completed by the consultant pharmacist on July 9, 2025, but the recommendations were not addressed. The DON further stated that the July 2025 MRR recommendations for Resident #7 were currently being worked on by the Nurse Practitioner (NP).On 9/4/25 at 11:07 AM, this surveyor requested a copy of the July 2025 MRR with provider responses. At 12:34 PM, the facility provided two July MRRs dated 7/9/25 for Resident #7. Review of the documentation revealed that the provider responses were signed and dated by the NP on 9/3/25, after surveyor intervention.This delay meant that pharmacy recommendations for Resident #7 were not reviewed or acted on until 56 days after they were written.

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	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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to ensure that 1) oral nutritional supplements and medication were properly stored and labeled. This was evident for 1 storage closet and 1 of 3 medication storage rooms. and 2) medications were stored properly. This was found to be evident for 1 out of 4 medication carts observed during the initial tour of the facility during a recertification survey.The findings include: 1. During an initial tour of the facility conducted on [DATE] at 6:17 AM this Surveyor observed Resident #102's Rosuvastatin tab 40 mg (milligram) blister pack and a large blue pharmacy bag of medications on top of the medication cart on the Mill Landing nursing unit. Resident #102 was observed sitting in a chair near the medication cart. No staff were present at the time of the observation. During a continued tour of the Mill Landing nursing unit this Surveyor observed Registered Nurse (RN) #20 in the 400 hallway which was located around the corner from where medication cart was located. During an interview conducted on [DATE] at 6:22 AM Registered Nurse (RN) #20 advised he was distracted by another Surveyor and left the medications unattended. He stated that the facility's policy and expectation is that all medication was to be stored in a locked room or cart when it's not being administered. On [DATE] at approximately 7:39 AM this surveyor advised the Director of Nursing (DON) and Nursing Home Administrator (NHA) of the concern. 2. Glucerna is a nutritional drink and formula designed for people with elevated blood sugar, while a Hi-Cal is a generic dense nutritional supplement for general calorie and nutritional support. Bisacodyl suppository is a medication inserted into the rectum to relieve constipation. On [DATE] at 6:48 AM, the surveyor observed the following expired oral nutritional supplements inside the storage closet: - 16 cartons of Glucerna with Carbsteady 1.5 calories with an expiration date of [DATE] - 4 bottles of HI-CAL 1 liter with an expiration date of [DATE] On [DATE] at 12:24 PM, during an inspection of 3 medication storage rooms. A box of expired Bisacodyl suppositories with an expiration date of 7/25 was found in the Chesapeake medication storage room. Licensed Practical Nurse (LPN #14) confirmed this finding and removed the box. On [DATE] at 12:48 PM, the Director of Nursing (DON) was informed of these findings and stated that staff education would be conducted.

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	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

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and record review, it was determined that the facility failed to ensure timely provision of necessary or recommended dental services for 1 resident (#34) out of 1 resident reviewed for dental care during the recertification and complaint survey.The findings include:On 09/02/2025 at 7:45 AM, during an interview with Resident #34, he/she stated, The facility cancelled my dentist appointment at the last minute in July 2025, and I really need to see the dentist because my tooth is bothering me.During review of Resident #34's medical record on 09/02/2025 at 8:15AM, it was revealed that on 07/14/2025, the physician requested a dental appointment for the resident.On 09/02/2025 at 8:30 AM review of Resident #34's medical record revealed that on 07/30/2025, nurse's notes documented that the resident's dental appointment needed to be postponed due to insurance. On 09/02/2025 at 9:00AM, during an interview with the Director of Nursing (DON) regarding Resident #34's dental appointment requested by the physician on 07/14/2025, the DON confirmed that the facility was unable to schedule the appointment due to insurance issues. When the surveyor asked what occurs when a resident does not have active insurance, the DON stated, I will follow up with the Administrator.On 09/02/2025 at 10:15 AM, during an interview with the Regional Assistant BOM regarding Resident #34's insurance, she stated that the resident was admitted on [DATE], transferred from another facility, with redetermination occurring after admission. The facility discovered that the resident's insurance was inactive on 07/11/2025.On 09/02/2025 at 10:40AM when asked Regional Assistant BOM, regarding the process for verifying insurance prior to admission, she stated that the facility reviews eligibility prior to admission and notifies the Department of Human Services (DHS) to inform the provider that the patient has been transferred. She further stated that her process is to process the paperwork as soon as possible. She confirmed that Resident #34's insurance was inactive and stated that the facility was not made aware of this until the dental appointment was being scheduled.On 09/02/2025 at 12:33 PM, during an interview with the facility Administrator regarding residents whose insurance is inactive or who do not have insurance and require dental care, she stated that if dental conditions are urgent, the facility uses an on-site provider (National Preventive Solutions). When asked about Resident #34's situation, she stated the resident prefers using outside providers. When asked if the facility offered the on-site option to the resident, she responded, I remember verbally communicating it to resident; however, I do not remember documenting it. The surveyor made the Administrator aware of the concern, and she confirmed that the facility failed to offer the on-site provider and acknowledged receipt. 09/03/2025 at 7:50AM resident reported to the surveyor that the facility did not offer on-site Dental services. I called and scheduled appointment myself. On 09/03/2025 at 11:27 AM, the Director of Nursing (DON) reported that the resident has a dental appointment scheduled for 10/16/2025 and that the appointment is included on the facility's transportation calendar.

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

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on review of medical records, observation and staff interviews, it was determined that the facility failed to provide liquids consistent with resident's needs. This finding was evident for 1 (#119) of 7 residents reviewed for hydration during the recertification survey. The findings include: Dysphagia is the medical term for difficulty swallowing.Aspiration is the inhalation of food, liquid or other foreign material into the lungs.Aspiration pneumonia is a type of lung infection that occurs when foreign materials, such as food, vomitus, or saliva, enter the lungs. During a medical record review for Resident #119 on 08/19/2025 at 5:35 PM it was revealed that he/she had a history of dysphasia and aspiration pneumonia. The resident had a current doctor's order for fluids to be thickened to a nectar consistency. During continued medical record review a progress note written by the Dietician was discovered and it reported that the resident had a high aspiration risk. During an observation on 9/02/25 at 8:44 AM Geriatric Nursing Assistant (GNA) #37 was observed giving a cup of water to Resident #119. He/she began drinking and immediately started coughing. During an interview with Unit Manager #18 on 9/02/25 at 8:44 AM he reported that Resident #119 was supposed to be on thickened liquids and he promptly removed the water from in front of the resident. During an interview with GNA #37 on 9/02/25 at 8:46 AM she reported she was not aware that Resident #119 required thickened liquids. She confirmed the water provided to Resident #119 was not thickened to a nectar consistency. During an interview with the Director of Nursing (DON) on 9/03/25 at 1:16 PM she confirmed that the Resident should have gotten thickened liquids. She advised that diet and drink orders are expected to be followed as prescribed. She reported she would work on a system to help staff identify which Residents require thickened liquids.

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

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record reviews and interview, it was determined that the facility failed to ensure the Quality Assurance Performance Improvement (QAPI) meetings had the required committee members. This was found to be evident for 2 out of 2 quarterly committee attendance sheets reviewed during the recertification survey.The findings include:According to Centers of Medicare and Medicaid Services (CMS) QAPI stands for Quality Assurance and Performance Improvement, a systematic, data-driven, and proactive approach to maintaining and improving the safety and quality of care in nursing homes, as mandated by the Affordable Care Act. It combines Quality Assurance (QA), which sets and ensures standards for care, and Performance Improvement (PI), which involves continuously studying and improving processes to prevent problems and enhance services and quality of life for residents. The QAPI framework involves staff, residents, and families in identifying problems and implementing solutions through comprehensive programs and detailed plans.During the review of the QAPI attendance sheets conducted on 09/02/25 at 7:09 AM, it was discovered that the Medical Director had not attended the QAPI meeting for January 2025, March 2025, April 2025, and May 2025. The Infection Preventionist did not attend QAPI meetings for January 2025 and May 2025.During an interview conducted on 09/04/25 at approximately 9:25 AM, the Nursing Home Administrator (NHA) acknowledged that the Medical Director and Infection Preventionist had not attended the required QAPI meetings. The NHA reported that going forward she would hold a google meet for the required members who could not attend the meeting in person.

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews, it was determined that the facility staff failed to screen and offer pneumococcal vaccines to eligible residents. This was evident for 1 (Resident #114) of 5 residents screened for immunizations.The findings include:On 8/28/25 at 9:40 AM a review of Resident #114's clinical record revealed that the resident was admitted to the facility in May 2025 with diagnoses which included Dementia, Adult Failure to Thrive, Muscle Wasting and Atrophy.Further review of Resident #114's clinical record failed to reveal the resident's pneumococcal vaccination status. The record did not indicate whether the facility offered or educated the Resident/Responsible Representative (R/RP) on the risks and benefits of receiving the pneumococcal vaccine. The resident's Minimum Data Set (MDS) assessment dated [DATE] Section O, 0300B stated If Pneumococcal vaccine not received, state reason: Answer 3. Not offered.On 8/29/25 at 9:35 AM in an interview RN Staff #13 stated that pneumococcal vaccinations are offered upon residents' admission to the facility. After a consent is obtained from the R/RP, a physician order is initiated, and the vaccine is administered. If the vaccine is refused, a declination form would be signed by the R/RP and kept in the resident's clinical record. RN Staff #13 reviewed Resident #114's clinical record and confirmed that there was no documentation of the resident's pneumococcal vaccination status, nor was there documentation to indicate whether the vaccine was offered or refused. On 9/02/2025 at 8:38AM during an interview with the surveyor, the Director of Nursing reviewed Resident #114's clinical record and confirmed that there was no documentation of the resident's pneumococcal vaccination status.

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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)

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

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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.

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to maintain 1) a safe environment. This was evident in 1 out of 2 rooms closed off for construction or repairs and 2) a sanitary environment in the laundry room. This was evident on all the floors throughout the laundry room.The findings include: 1. During an interview with Resident #19 on 8/20/25 at 7:37 AM the resident reported the Resident Room beside room [ROOM NUMBER] had been closed and under construction for 2 years because it had a leak in the roof. During an observation of the room next to room [ROOM NUMBER] on 8/20/25 at 7:40 AM it was revealed that the room was not labeled but had a sign on the door stating the room was Under Construction and Authorized Personnel Only. There was no lock on the door or any other barrier to prevent entry from wandering or interested Residents. During continued observation of the room under construction on 8/20/25 at 7:30 AM it was discovered to have a puddle of water inside the room on the floor and on top of a bedside stand near the doorway. The floor beside the doorway had a reddish-brown stain around the puddle. The bedside stand had staining on top with wood peeling away and splitting on its sides. There were 3 Chairs, 7 tubular replacement lights, 5 mattresses and 3 bed frames stored in the room. The ceiling had a ceiling tile missing, another ceiling tile was broken in half and degrading and 3 other ceiling tiles had reddish-brownish spots. During an interview with the Regional Maintenance Director on 8/21/25 at 1:56 PM he reported the room was under construction. It was previously Resident room [ROOM NUMBER] and it is not currently being used as a resident room but as a storage room. He confirmed the room had been closed for over two years due to a leak in the roof. He reported several attempts had been made to repair the leaking roof, but it still needed more work. During an interview with the Administrator on 9/04/25 at 1:16 PM she agreed that room [ROOM NUMBER] was a safety concern for residents if they entered the room and reported that maintenance was supposed to put a lock on it. 2. On 08/28/25 at 1:15 PM the surveyor did a walkthrough of the laundry room with the Maintenance/EVS Director. The laundry room was visibly dirty with large scattered black marks on the white floor tiles throughout the laundry room. The surveyor also observed several cracked tiles in the room housing the washing machines. One washing machine was in operation. When asked, the Maintenance/EVS Director stated that there was only one working machine in the laundry room. On the floor under the door of the washing machine was a wet towel with black spots. In the clean area of the laundry room, in front of the folding table, and at the corners of the door were several patches of brown-like substances on the white floor tiles. During the walkthrough and interview, the Maintenance/EVS Director was made aware of the surveyor's concern regarding the condition of the laundry room. The Maintenance/EVS Director confirmed the findings and stated that the laundry room needed cleaning This is an old building, I do not think much could be done with the floor tiles On 9/2/25 at 10:14 AM in an interview, the concerns regarding the laundry room were brought to the (continued on next page)

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attention of the Administrator. The Administrator took notes but did not comment on the condition of the laundry room.

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

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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 review of staff educational files and interviews it was determined that the facility failed to ensure Geriatric Nursing Assistant (GNA) completed a required annual education course. This was found to be evident for 5 (#17, #35, #39, #40, & #41) out of 5 GNA educational files reviewed during the recertification survey.The findings include: A compliance and ethics program is a systematic effort by an organization to prevent, detect, and resolve violations of law, regulations, and company policies by promoting a culture of integrity, ethical behavior, and legal adherence among its employees and agents. Key components typically include a written Code of Conduct, clear policies and procedures, robust training, risk assessment, a confidential reporting system for allegations, disciplinary actions for violations, and oversight by high-level management. During a record review of Geriatric Nursing Assistant (GNA) #17, #35, #39, #40, & #41 educational files conducted on 09/02/25 at 6:30 AM revealed there was no training record for the required annual Compliance and Ethics Program. During an interview conducted on 09/02/25 at approximately 9:10 AM, the Nursing Home Administrator (NHA) provided a monthly education calendar for 2025 that listed training courses that were issued by the facility's corporate office. A review of the monthly education courses showed that for the month of November 2025 Compliance and Ethics Program would be conducted. During a continued interview, this Surveyor expressed the concern that there was no record of a previous educational course completed for Compliance and Ethics Program in GNA #17, #35, #39, #40, & #41 educational employee files. The NHA stated that the facility conducted a facility wide education fair that should have included the Compliance and Ethics Program in May of 2025. During an interview conducted on 09/04/25 at approximately 9:30 AM the Human Resource Director (HRD) provided the education In-Service Attendance Record for dated 05/09/25. The following education was provided to GNAs #17, #35, #39, #40, & #41: Abuse, Active Shooter, ADL Doc., Covid 19, Infection Control, Cultural Diversity, Dementia, Fire and Disaster Planning, HIPPA, Nutrition Hydration, oral, Pain management, Incontinence skin care, cath., wounds, resident rights, restorative nsg, and trauma informed care. A Review of the educational In-Services conducted on 05/09/25 did not include the Compliance and Ethics Program. Durning a follow up interview with the NHA conducted on 09/02/25 at approximately 9:45 AM, the NHA acknowledged that the Compliance and Ethics Program was not included in the educational in-service fair conducted May 2025.