STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215013	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Mary's Nursing Center Inc	21585 Peabody Street Leonardtown, MD 20650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on administrative review and interviews with facility staff it was determined the facility failed to ensure staff reported allegations of abuse timely after bruising of unknown origin on a resident was discovered This was found to be evident in 1(#74) of 6 residents' facility reported incidents reviewed during the annual Medicare/Medicaid survey. The findings include:Intake # 2657368 was reviewed on 3/11/26 at 11:00AM for resident # 74 for an injury of unknown origin. Intake details indicate that the resident was noted with bruising to the right arm and reported that an aide was rough with him/her. The abuse allegations were unsubstantiated.Further review of the facility's investigation on the same date revealed a statement interview form signed by GNA (#25) that on 10/30/25 she went to get Resident #74 changed and ready for bed. The resident complained right shoulder was hurting. The GNA saw the resident's arm and reported it to the nurse (#17), and the nurse went to assess it.Review of another interview statement signed by Registered Nurse (RN) (#17), revealed that on 10/31/25 she was made aware of Resident #74's right arm bruising by GNA (#25) who was providing care to the resident. The resident complained of pain to right shoulder and routine Tylenol was provided and was effective. This nurse reported to the supervisor.During an interview with the Director Of Nursing (DON, #2) on 3/11/26 at 1:45 PM, she confirmed that the nurse, staff #17 failed to report Resident #74's allegations and that disciplinary actions were taken for failure to report timely. She provided a copy of the employee disciplinary record to the survey team, and it revealed the following:On 10/30/25 at approximately 10:30pm a bruise on a resident was discovered by a GNA and reported to the nurse (#17).The Resident (#74) reported to the nurse that the bruise was caused by the GNA being rough with him/her, and the nurse reported to the on-call provider, but never reported to the nursing supervisor that night. The nurse waited until the following morning at 6:30am to notify the DON of the allegation that the bruise was caused from the GNA being rough.All concerns were discussed with the Administration during exit conference on 3/12/26.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered by the physician and according to accepted standards of nursing practice, including administering medications at the correct time. This was evident for 3 (#127, #58, #128) of 4 residents observed and reviewed for medication administration. According to accepted standards of nursing practice, including the patient medication rights outlined in the Maryland Nurse Practice Act, medications must be administered according to the right time, meaning medications should be administered at the time intended by the prescriber to maintain therapeutic effectiveness. The Findings Include: 1. A medication administration observation was conducted on 03/10/2026 at 10:05 AM for Resident #127. Staff #15, a Licensed Practical Nurse (LPN), reviewed the electronic medication administration record (eMAR) as she prepared medications for the resident. The computer screen displayed -Senna-S oral tablet 8.6-50 mg with a scheduled administration time of 8:00 AM. Staff #15 administered the medication to Resident #127 at approximately 10:00 AM. Review of physician orders for Resident #127 on 03/10/2026 revealed the following order: -Senna-S oral tablet 8.6-50 mg – Give two tablets by mouth two times a day for constipation. Staff #15 administered the medication outside of the scheduled physician-ordered administration time. 2. A medication administration observation was also conducted on 03/10/2026 at 10:30 AM for Resident #58. Staff #15 reviewed the eMAR as she prepared medications for the resident. The eMAR displayed: -Bupropion Extended Release (ER) 150 mg – scheduled administration time 9:00 AM-Eliquis 5 mg – scheduled administration time 9:00 AM Staff #15 administered these medications to Resident #58 at approximately 10:25 AM, which was outside the scheduled administration time. Review of physician orders for Resident #58 on 03/10/2026 revealed the following: -Bupropion ER (12-hour) 150 mg – Give one tablet by mouth two times a day for depression.-Eliquis 5 mg – Give one tablet by mouth two times a day for atrial fibrillation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #15 administered the medications outside of the physician-ordered scheduled administration time. 3. On 03/09/2026 at 1:30 PM, the surveyor reviewed Complaint #364453, submitted to the Office of Health Care Quality (OHCQ) on 02/02/2025, which alleged the facility failed to ensure medications were administered in a timely manner to Resident #128 during 2024 and 2025. On 03/10/2026 at approximately 1:00 PM, an interview was conducted with the Director of Nursing (DON), Staff #2, regarding medication administration timeliness and the assignment of licensed staff responsible for administering medications on two different floors. The DON stated that the practice of medication staff administering medications on two different floors had been in place since 2024 and that the process had been working well. On 03/10/2026 at approximately 1:45 PM, the surveyor reviewed the Medication Administration Audit Report for Resident #128 with the Quality Assurance Nurse, Staff #3. The surveyor selected random dates in 2024 and 2025 to verify whether medications prescribed for Resident #128 were administered within the expected time frame. Staff #3 confirmed that there were multiple examples of medications not administered in a timely manner. On 03/10/2026 at approximately 3:00 PM, Staff #3 provided documentation of medication administration records for Resident #128. Review confirmed that the following administrations occurred outside the scheduled times: 12/01/2024 -Eliquis 5 mg, scheduled for 0800, administered at 09:46 AM-Gabapentin 100 mg, scheduled for 0800, administered at 09:46 AM 01/02/2025 -Eliquis 5 mg, scheduled for 0800, administered at 09:15 AM-Gabapentin 100 mg, scheduled for 0800, administered at 09:15 AM-Eliquis 5 mg, scheduled for 2000, administered at 21:40-Lantus insulin 14 units, scheduled for 2000, administered at 21:40 01/04/2025 -Eliquis 5 mg, scheduled for 0800, administered at 09:55 AM-Gabapentin 100 mg, scheduled for 0800, administered at 09:55 AM-Eliquis 5 mg, scheduled for 2000, administered at 22:04-Lantus insulin 14 units, scheduled for 2000, administered at 22:04 01/05/2025 -Gabapentin 100 mg, scheduled for 0800, administered at 09:48 AM-Eliquis 5 mg, scheduled for 2000, administered at 21:26-Lantus insulin 14 units, scheduled for 2000, administered at 21:26 10/05/2025 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Eliquis 5 mg, scheduled for 2000, administered at 21:13-Lantus insulin 14 units, scheduled for 2000, administered at 21:20 An interview was conducted with the Director of Nursing (DON) on 03/10/2026 at 12:55 PM. The DON acknowledged the identified concerns and stated that when medications appear late on the electronic medication administration record, the nurse should notify the physician to obtain direction regarding medication administration.

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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. Based on observation and staff interview it was determined the facility failed to ensure safe medication administration and proper assessment for self-administration. This was evident for 1 (#110) of 4 residents reviewed for medication administration.The findings include:Medication pass observation was conducted on 3/9/26 at approximately 11:14 AM. Licensed Practical Nurse (LPN), Staff #22, was observed administering medications to residents. At that time, Resident #110 was observed entering his/her room via wheelchair holding medication in hand.Staff #22, accompanied by the surveyor, entered the resident's room and asked if the medication had been taken. Resident #110 responded, yes. Staff #22 retrieved the medication, identified as Saline Mist Nasal Spray, and returned to the medication cart.When questioned by the surveyor regarding how much medication the resident had administered, Staff #22 stated, I don't know, I should have observed (him/her). Staff #22 further acknowledged that she was attending to multiple residents and should have administered the medication rather than allowing the resident to self-administer. Staff #22 confirmed that Resident #110 did not have a physician order or assessment authorizing self-administration of medications.An interview was conducted with the Director of Nursing (DON) on 03/10/2026 at 12:55 PM. The DON acknowledged the identified concerns and stated that although Resident #110 was alert and oriented, the resident must be assessed and have a physician order to self-administer medications. The DON confirmed that the nurse should have administered the medication to Resident #110.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on medical record review, observation, and staff interview, the facility failed to ensure a medication was clinically indicated and evaluated for continued need. This occurred for 1 (#32) of 5 residents reviewed for unnecessary medications during the annual survey.The findings include:Review of the medical record for Resident #32 on 3/10/2026 revealed the resident was receiving Enoxaparin Sodium Solution 40 mg/0.4 mL, administered 40 mg subcutaneously once daily for deep vein thrombosis (DVT) prophylaxis.Further review of the medical record revealed the resident was admitted to the facility in February of 2026 with documentation indicating immobility. The clinical record revealed the resident was evaluated by Physician Assistant-Certified (PA-C) staff # 28 on 3/5/2026. However, review of the clinical record lacked documentation identifying the clinical rationale for the continued use of Enoxaparin (Lovenox) after the resident was no longer immobile.During an interview with Resident #32 on 3/9/2026 at 12:17 p.m., the resident stated s/he did not know why s/he was receiving a daily injection and reported s/he was not taking this medication at home, stating s/he was only admitted for rehabilitation and planned to return home.During an interview with the Director of Nursing (DON) on 3/10/2026 at 10:00 a.m., the DON stated she was unaware of the reason the resident continued to receive the medication.On 3/10/2026 at 11:00 a.m., an interview was conducted with the Speech Therapist, who also serves as the Rehabilitation Director, Staff #7, who verified the resident ambulates and has been ambulatory since admission to the facility.During a follow-up interview with the DON on 3/10/2026 at 12:00 p.m., the DON stated the physician had been notified and the Enoxaparin (Lovenox) was discontinued.During an interview with PA-C staff # 28 on 3/11/2026 at 12:13 p.m., she stated she does not visit the facility frequently and that when she evaluated the resident on 3/5/2026, the resident was sitting at the time of the visit, and she was not aware the resident was ambulatory. The PA-C staff # 28 stated that if she had known the resident was ambulating, she would have discontinued the Lovenox. She was informed that the primary physician discontinued the medication on 3/10/2026, to which she responded, good.