STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215039	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care Center	415 South Market Street Havre DE Grace, MD 21078

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the investigation of complaints, medical record review, and staff interviews, it was determined that the facility failed to update residents' (and/or responsible parties') wishes related to life-sustaining treatment and assess residents' capacity to make decisions in a timely manner. This failure was evident for one (Resident #8) of the eight residents whose care was reviewed during this complaint survey.The findings include:A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient.As a portion of the investigation into complaint #361874, the surveyor reviewed Resident #8's medical records on [DATE] at 8:30 AM. The review revealed that the resident was their own Responsible Party (RP) and had a most recent MOLST dated [DATE] at 12:31 PM, which indicated No CPR option B, palliative and supportive care by the patient.Further review of Resident #8's medical record revealed that the resident was transferred to the hospital due to condition changes on [DATE] and re-admitted to the facility on [DATE]. Staff #4 (Social Worker) wrote a progress note on [DATE] at 9:13 AM stating, Resident wished to attempt CPR. Resident presented as alert and oriented. Social Worker will continue to follow. An additional progress note dated [DATE], written by Staff #4, stated, MOLST attempt CPR.Resident is their own decision maker, children are involved in their care.The surveyor conducted a continuous review of Resident #8's medical records. The review revealed that the resident had another hospital transfer on [DATE] due to a lethargic condition and was readmitted on the same day. On the following day of readmission ([DATE]), Staff #4 documented that: The resident returned from the hospital on 5/14 with a MOLST dated [DATE]. Visited with [resident name] and this writer is not comfortable discussing their code status. A fax was sent to [attending physician] requesting a re-evaluation of capacity. Capacity form and a blank MOLST form were left on the chart. Further documentation by Staff #4 at 4:52 PM on [DATE] showed that the staff spoke with the son/RP to discuss the MOLST, and the attending physician said to keep the one that was on the resident's chart (at the physician's office) dated [DATE], DNR-B per patient. During an interview with the Director of Nursing (DON) and Staff #4 on [DATE] at 1:40 PM, the surveyor reviewed Resident #8's MOLST and progress notes. The DON and Staff #4 confirmed that the resident was their own responsible party, able to make decisions before their mental status changes on [DATE]. However, there was no capacity evaluation completed in a timely manner, and the medical records, including progress notes, were unclear as to who the decision maker was. The DON and Staff #4 validated this finding. Additionally, Staff #4 validated that there were discrepancies in Resident #8's MOLST. Staff #4's assessment on [DATE] indicated the resident clarified that they wanted a Full Code; however, the MOLST was recorded as DNR-Part B, even though it was documented later than Staff #4's notes. The DON agreed that the facility should have obtained a Full Code MOLST for Resident #8 and then subsequently revised it to DNR.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on the investigation of complaints, medical record review, and interviews with facility staff, it was determined that the facility failed to ensure that changes in residents' condition were notified to the physician in a timely manner. This failure was evident for one (Resident #8) of the eight residents whose care was reviewed during this complaint survey.The findings include: As part of the investigation into complaint #361874, the surveyor reviewed Resident #8's medical records on 11/05/25 at 8:30 AM. The review revealed the following: -Staff #11 (Registered Nurse) documented in a progress note on 5/12/25 at 12:38 PM that Resident #8 was tearful with increased confusion.-Staff #4 (Social Worker) recorded Resident #8's confusion on 5/12/25 at 1:26 PM in a progress note, stating: [Resident's name] was tearful during our exchange. Unable to provide year, month stating 'I'm confused.'However, there was no documentation indicating that Resident #8's change in mental status was notified to the provider.In an interview with the Assistant Director of Nursing (ADON) on 11/05/25 at 12:09 PM, she confirmed that a resident's change in mental status should be considered a change in condition, which must be documented in the electronic medical record system and communicated to the provider.On 11/05/25 at 2:32 PM, the Director of Nursing (DON) verified that there was no documentation to support that Resident #8's change in mental status had been notified to the provider. She validated the concern.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on an investigation of intakes, reviewing medical records, and interviewing facility staff, it was determined that the facility failed to ensure that a resident's Treatment Administration Records (TAR) were correctly documented. This was evident for one (Resident #8) of eight residents reviewed for care during this complaint survey.The findings include:During the investigation of complaint #361874, on 11/05/25 at 8:30 AM, it was noted that Staff #8 (Licensed Practical Nurse) wrote a progress note on 5/14/25 at 7:14 PM as returned from hospital without boots.Further review of Resident #8's progress notes revealed that multiple staff documentation about the resident's boots, which could not be found. Specifically: A note dated 5/15/25 by Staff #4 wrote, Resident #8 reported that he/she don't know where his/her blue boots were he/she was supposed to wear them. The nurse clarified that there were no boots. A note dated 5/16/25 by Staff #4 wrote, Resident asked for his/her blue boots. Nursing to follow up. A note dated 5/17/25 by Staff #9 (Registered Nurse) wrote that they were unable to find protector boots during the evening shift, and they were still missing. A note dated 5/18/25 by the attending Physician documented that the resident wants his/her boots back and that the physician was told they must be ordered: Please order the boots he/she wants.The review of Resident #8's TAR for May 2025, on 11/05/25 at 10:30 AM, revealed that the resident had an order of Heel protector boots on at all times, remove for bathing every shift for heel protection from 4/24/25 to 5/27/25. However, the TAR documentation for all shifts from 5/14/25 to 5/18/25 indicated that the boots were applied.During an interview with the Director of Nursing (DON) on 11/06/25 at 12:19 PM, the surveyor reviewed Resident #8's TAR and progress notes with the DON. She validated that there were discrepancies regarding Resident #8's boots: progress notes documented they were missed, but the TAR documented they were applied.