STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215058	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alice Byrd Tawes Nursing Home	201 Hall Highway Crisfield, MD 21817

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and facility staff interview, the facility staff failed to protect and value resident's dignity (Resident #38). This was evident for 1 out of 1 resident reviewed for dignity. The findings include: On 3/3/26 at 7:40am, the surveyor observed Resident #38 sitting in a wheelchair in front of the 2nd floor's nursing station attempting to get nursing staff's attention by stating excuse me repeatedly. The resident manually moved his/her wheelchair closer to the 2nd floor's nursing station and stated excuse me to LPN #17 which he/she was on the phone. LPN #17 ignored the resident. Infection Preventionist (IP) #14 walked past LPN #17 and the resident while the resident stated excuse me again. IP #14 also ignored the resident. The resident continued to attempt to get nursing staff's attention by excuse me without success. The closest nursing staff member to the resident was LPN #17 and LPN #17 continued to ignore him/her. When IP #14 re-entered the 2nd floor nursing station, the surveyor informed IP #14 that Resident #38 was requesting assistance. IP #14 asked the resident what he/she wanted and the resident requested something to drink. IP#14 provided the resident with a drink. Interview with the Director of Nursing (DON) on 3/4/26 at 12:30pm, the surveyor informed the DON of the interaction between Resident #38 and the 2nd floor nursing staff on the morning of 3/3/26. The DON stated that he/she was unaware of issues with residents being ignored by nursing staff. The DON stated that he/she would speak to the nursing staff about the incident.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on random observations it was determined that the facility failed to maintain a homelike environment for the residents of the 3rd floor. This was evident for 1 of 2 units (3rd floor). The findings include:Upon entering the 3rd floor on 3/3/26 at 9:00 AM and entering the open sitting area, this surveyor observed that the television was on, however, there was a black bar covering half of the screen on the left side. The tour of the unit and observations continued throughout the morning. Returning to the unit at approximately 11:50 AM on 3/3/26 to review medical records, the same observations were made of the television on in the sitting room with the black bar covering half of the screen on the left side, with the same television game show on.Observations of the 3rd floor unit on 3/4/26 at 10:09 AM revealed the same observations of the television on with the black bar covering the left half of the screen, with the same television game show on. This surveyor sat in the sitting area to complete observations at this time. A popular game show was on, however, only the host could be seen and not the contestant due to the back bar. A closer look at the television and the black bar looked revealed it to be an option menu from a button that was pushed on the remote, and the screen was just left up. During this observation, this surveyor noted staff interacting with residents that were placed in front of the television-that was still not fully displaying the show. At 10:31 AM, 22 minutes after this surveyor sat down and 26 hours after initially walking onto the floor and making observations, the television channel was changed and adjusted to a full screen that could be viewed and enjoyed by the residents. This ongoing observation and concern for a homelike environment for the residents was reported to the DON and NHA on 3/4/26 at 12:43 PM. The DON stated that she herself had been on the 3rd floor and had not identified the concern, but acknowledged that at times you become complacent and need other eyes to pick up on things.

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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. Based on medical record review and interview with the facility staff it was determined that the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the resident's status. This was found to be evident for 1out of 5 residents (R # 4) reviewed during the investigative stage of the survey.The findings include: The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need.A review of the medical record on 3/4/26 at 4:50 PM for Resident #4 revealed a completed MDS on 1/17/26 identifying Resident #4 as receiving an insulin injection for 7 days during the lookback period. A concurrent review of the medication administration record (MAR) failed to reveal that Resident #4 received any insulin injections for this most recent look back period for the coded MDS completed on 1/17/26. Interview on 3/5/26 with staff #8 revealed that she was the one that completed the MDS for Resident #4 in January 2026. She reviewed the MDS that was submitted concurrently with the MAR in the presence of the survey team. She verbalized that there was a discrepancy and would complete a modification.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, medical record review and interview, the facility failed to monitor a resident's nutrition status and failed to recognize a resident's need for feeding assistance and inform the dietitian/physician. This was evident for 1 of 2 residents (Resident #8) reviewed for nutrition. The Findings include: On 3/3/26 at 8:00am, the surveyor observed Resident #8 during breakfast attempting to feed him/herself. The resident was having difficulties with putting the food in his/her mouth due to tremors in the hands. The surveyor attempted to interview the resident, but the resident was lethargic and difficult to understand. On 3/3/26 at 8:35am, the surveyor interviewed GNA #12 regarding Resident #8's status and his/her ability to feed him/herself. GNA #12 stated that the resident was able to feed him/herself. The surveyor pointed out that the resident was observed having trouble feeding her his/herself due to tremors in the hands. GNA #12 stated that the resident normally picks at (his/her) food and requires no assistance with feeding. On 3/4/26 at 8:20pm, the surveyor observed Resident #8 during breakfast. The surveyor observed for a 2nd time that the resident was having trouble feeding him/herself due to tremors in the hands. On 3/4/26 at 10:30am, the surveyor reviewed Resident #8's medical record. The resident's diagnosis stated that he/she had Parkinson's disease with tremors. The resident was being treated for tremors, and the treatment was noted to be successful. Progress notes revealed that the dietitian assessed the resident as being malnourished on 1/15/26. Further review of progress notes found the resident was receiving nutritional supplementation, but the resident was eating a portion of the supplement or refusing to take the supplement. Review of the resident's care plan revealed that the facility had no interventions for reduction in the resident's intake. On 3/5/26 at 10:48am, the surveyor interviewed medical director #7 regarding Resident #8's nutritional status. The surveyor explained that the resident was observed having difficulty feeding his/herself breakfast on 3/3/26 and 3/4/26. Medical director #7 stated that he/she was unaware of feeding issues and he/she was aware that the resident had a reduction in intake. Medical director #7 also stated that he/she expected the GNAs to provide feeding assistance when the resident is observed to have difficulties feeding him/herself or when the resident has decreased intake at meals. The surveyor pointed out that this expectation was not known to the GNA's. On 3/5/26 at 9:30am, the surveyor interviewed Dietitian #13 regarding Resident #8's nutritional status. The surveyor asked Dietitian #13 about treatments/supplementation to assist with mitigation of weight loss. Dietitian #13 stated that supplementation is given for snacks and after dinner as well as protein supplementation was ordered during medication administration. The surveyor asked about issues with tremors causing difficulties with the resident feeding him/herself. Dietitian #13 stated that he/she did not observe the resident having difficulties with feeding him/herself. The surveyor pointed out the resident was observed having difficulties feeding him/herself during breakfast due to tremors. Dietitian #13 admitted that he/she normally observed the resident later in the day and did not observe the resident's tremors. On 3/5/26 at 10:00am, the surveyor informed the Director of Nursing (DON) of surveyor observations of Resident #8 having difficulties feeding him/herself during breakfast on 3/3/26 and 3/4/26. The DON stated that he/she was unaware of the resident's issues feeding him/herself. The surveyor also informed the DON that interviews with medical director #7 and dietitian #13 revealed that both providers were unaware of the issues with the resident feeding him/herself but GNA #12 was aware of the resident's feeding difficulties.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on medical record review, staff interview and review of facility policy, it was determined that the facility failed to maintain ongoing communication with the dialysis facility. This was evident during the review of 1 of 1 Residents (#11), (all residents) who currently attend dialysis. The findings include:Review on 3/3/26 of the medical record for Resident #11 revealed that s/he currently received dialysis and according to the matrix provided to the survey team s/he is the only resident currently receiving dialysis.A review of the dialysis communication pages in the binder revealed inconsistencies in the completion of the assessments for each visit to dialysis and the return to the facility from dialysis. Interview with LPN #17 on 3/5/26 at 11:00 AM regarding the dialysis communication book, and process revealed that the assigned dialysis book goes with the resident to the dialysis center. LPN #17 was asked about the form with the 3 sections, she reviewed the book and said that dialysis needs to fill out the middle section, and the night shift does the top, she was not familiar with filling out the bottom portion. Interview on 3/5/26 at 11:02 AM with RN staff #16 verbalized that the night shift fills out the top section, dialysis completes middle and the facility does its own vitals upon the residents return. She was then asked if the form is incomplete, what do you do? She stated that you are supposed to call the dialysis center back but ?I don't think that they do.' She was shown all the blank pages in Resident #11's dialysis book. She verbalized that she was not surprised. The facility NHA was interviewed on 3/5/26 at 11:12 AM and the surveyors' concerns were shown to her regarding the blank dialysis forms. The NHA stated that the team knows what to do with the forms and when the dialysis center fails to complete their portion. Facility policy on dialysis communication was reviewed on 3/5/26 revealed the basics for completing the dialysis communication form, to be completed prior to leaving the facility, at dialysis center and upon return. The policy also addresses the procedure if any area is missing. The concerns were followed up on with the facility DON and NHA throughout the remainder of the survey and again on exit 3/6/26.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews of facility staff, it was determined that food service employees failed to ensure that sanitary practices were followed and safe food handling practices were followed to reduce the risk of foodborne illness. This was evident during the initial tour of the kitchen and only 1 observation. The findings include:During the tour of the kitchen and observation of staff practices, this surveyor observed the following at 3/3/26 at 8:16 AM: On the cold prep table a large metal container holding milk was sitting unattended. Within arm's reach of the container of milk was an open bottle of water, a coffee cup and a personal black thermos with red hearts on it. Additionally, there was a white rag sitting next to and touching the metal pan of milk with orange, brown and black stains and flecks of debris.At 8:18 AM staff #9, the lead cook was notified of the observations and concerns and directed the staff to discard the container of milk, he had already removed the personal drinking items when he saw this surveyor making observations and notations. On 3/4/26 at 1:21 PM this Surveyor met with the Kitchen Manager, staff #10 and was able to update him with the observations and concerns.

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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 record reviews and interviews it was determined that the facility failed to ensure medical records were complete and accurate. This was evident for 1 (Resident #5) of 1 Residents reviewed for complete and accurate medical record documentation.The findings include:During a review of the Task Administration Record (TAR) for Resident #5 on 3/06/2026 at 7:51 AM it was discovered that Resident #5 had orders for wound care that was not signed off as being completed. The orders include:An order for Clean left buttock open area with Normal Saline Solution and cover with AG and dry sterile dressing was not signed off as completed on 2/23/2026.An order for Clean right calf open area with Normal Saline Solution, pat dry and cover with damp AG and dry sterile dressing every dayshift for wound care was not signed off as completed on 2/23/2026.An order to Clean wound to right outer elbow with Normal Saline Solution, pat dry, cover with Xeroform and dry sterile dressing was not signed off as completed on 2/23/2026.During an interview with the Director of Nursing (DON) on 3/06/2026 at 9:05 AM she confirmed that wound care should be completed if there is an order and when wound care is performed on a Resident it should be signed off in the TAR. She reported she can't confirm that wound care was completed on Resident # 5 on 2/23/2026 because it was not signed off as completed and it's unacceptable that it was not documented.