STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. Building B. Wing	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adelphi Nursing and Rehabilitation Center	1801 Metzerott Road Adelphi, MD 20783

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview, record review, and facility policy review, the facility failed to develop a care plan to address how staff should care for and monitor a resident's pacemaker for 1 (Resident #16) of 4 sampled residents reviewed for a pacemaker.Findings included:Review of a facility policy titled Care Planning, effective 11/01/2019, revealed Policy A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient.An admission Record indicated the facility admitted Resident #16 on 08/11/2025. According to the admission Record, the resident had a medical history that included diagnoses of atrial fibrillation and heart failure.Continued review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/16/2025, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment.Resident #16's Care Plan Report included a focus created 08/19/2025 and revised 09/10/2025 that indicated the resident was at risk for cardiac complications secondary to atrial fibrillation, congestive heart failure, severe tricuspid regurgitation, hypotension, cardiomyopathy, and severe tricuspid regurgitation. According to the Care Plan Report, there was no focus area that specified the resident had a pacemaker or interventions that directed staff how to monitor the resident's pacemaker for proper functioning.Resident #16's Order Summary Report revealed an order dated 10/16/2025, that specified FYI [for your information]: Resident has pacemaker device, every shift.During an interview on 10/16/2025 at 6:01 PM, Resident #16 acknowledged they had a pacemaker. During an interview on 10/20/2025 at 8:54 AM, the Director of Nursing stated Resident #16's pacemaker should be addressed on their care plan.

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 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 interview, record review, document review, and facility policy review, the facility failed to ensure licensed nursing staff had orders to monitor a resident's pacemaker for proper functioning for 1 (Resident #6) of 4 sampled residents reviewed for a pacemaker. The facility further failed to ensure staff reported a resident's fall to the licensed nursing staff so that an assessment of the resident could be done before the resident was picked up from the floor for 1 (Resident #13) of 4 sampled residents reviewed for accidents. Findings included: 1. An admission Record revealed the facility admitted Resident #6 on 11/12/2015. According to the admission Record, the resident had a medical history that included diagnoses of cardiomyopathy, presence of heart assist device, and congestive heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) of 14, which indicated the resident had intact cognition. Resident #6's Care Plan Report included a focus area initiated 08/12/2022, that indicated that the resident had a pacemaker related to dysrhythmias. According to the Care Plan Report, there was no interventions that directed staff how to monitor the resident's pacemaker for proper functioning. Resident #6's Order Summary Report revealed an order dated 05/13/2025 that specified, FYI [for your information]: Patient has a pacemaker. There was no evidence of any orders for the licensed nursing staff to monitor the resident's pacemaker for proper functioning. During an interview on 10/16/2025 at 3:45 PM, Resident #6 stated they had a pacemaker and could not remember the last time staff checked their pacemaker. During an interview on 10/20/2025 at 9:33 AM, Nurse Practitioner #5 stated the nurses would have an order to monitor a resident's external monitoring device (pacemaker) to see if the device worked properly. During an interview on 10/17/2025 at 1:23 PM, the Director of Nursing stated if a resident admitted to the facility with a pacemaker, there should be a physician's order for how the pacemaker should be monitored and if not, the staff should contact the resident's cardiologist to get orders. During an interview on 10/20/2025 at 1:31 PM, the Administrator stated Resident #6's pacemaker was not being monitored by the facility staff. 2. A facility policy titled Falls Management Program, effective 01/29/2024, revealed Fall Occurrence 1. Do not move or reposition patient until a licensed nurse had completed a physical and cognitive assessment. A license nurse will: * Assess, intervene, and promptly provide the necessary interventions for any patient experiencing a fall. An admission Record revealed the facility admitted Resident #13 on 10/19/2021. According to the admission Record, the resident had a medical history that included muscle weakness and difficulty in walking. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2025, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance to roll left and right. Resident #13's Care Plan Report included a focus area dated 10/19/2021, that indicated the resident was at risk for falls. Interventions directed staff to anticipate and meet the resident's needs (initiated 10/19/2021) and to be sure the resident's call light was within reach and encourage them to use it for assistance as needed (initiated 08/08/2022). The facility Nursing Investigation Form dated 10/03/2025, revealed the resident reported they rolled out of bed on 10/02/2025. During an interview on 10/15/2025 at 2:15 PM, Geriatric Nursing Assistant (GNA) #14 stated she was assigned to care for Resident #13 on 10/02/2025. GNA #14 stated she was assisting Resident #13's roommate with care when she heard a noise and noticed that Resident #13 had fallen out of bed. GNA #14 stated she got the first person she saw, which was a housekeeper, to help assist her get Resident #13 off the floor. GNA #14 stated she and the housekeeper picked Resident #13 off the floor and placed the resident back in bed. GNA #14 stated Resident #13 had no complaints of pain. GNA #14 stated on the following day (10/03/2025), Resident #13 complaining of pain in their leg, so the fall was reported. GNA #14 stated she did not report the fall on 10/02/2025 because the resident stated they were fine and had no complaints of pain. GNA #14 stated she received training after the incident and she was instructed to notify a nurse of a resident's fall so that the nurse could assess the resident before the resident was picked up from the floor. During an interview on 10/20/2025 at 9:27 AM, Housekeeper #22 stated she remembered she was near Resident #13's room, and GNA #14 asked her to help put the resident in bed. During an interview on 10/20/2025 at 10:21 AM, Unit Manager (UM) #1 stated she was notified on 10/03/2025 of Resident #13's fall. UM #1 stated she asked Resident #13 what happened and the resident reported they rolled out of bed. UM #1 stated she asked Resident #13 who picked them up from the floor, and the resident told her it was a GNA. UM #1 stated she spoke to GNA #14, who told her she was on the other side of Resident #13's room taking care of Resident #13's roommate when she heard Resident #13 call out for help. According to UM #1, GNA #14 stated it was Housekeeper #22 who helped her put the resident back in bed. Per UM #1, GNA #14 stated she did not tell the nurse what happened. UM #1 stated she educated GNA #14 and Housekeeper #22 about assisting the resident and reporting what happened. During an interview on 10/20/2025 at 1:06 PM, the Director of Nursing (DON) stated GNA #14 and Housekeeper #22 were written up after the 10/02/2025 incident and were both given education. The DON stated her expectation after a resident fall was for the fall to be reported to the nurse and for the nurse to immediately assess the resident. GNA #14's Corrective Action signed by GNA #14 and UM #1 and dated 10/03/2025, indicated Written educated employee that whenever a resident has a fall or is noted on the floor, employee must always go straight to the nurse and let the nurse know before picking up the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Housekeeper #22's Corrective Action signed by Housekeeper #22 and UM #1 and dated 10/03/2025, indicated Written educated employee that she cannot help any staff when a resident is noted on the floor. During an interview on 10/20/2025 at 4:34 PM, the Administrator when Resident #13 fell out of bed on 10/02/2025, GNA #14 got help from Housekeeper #22 to get the resident back in bed. The Administrator stated when an incident happened, the staff must notify the charge nurse.

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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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to document a behavioral incident in the medical record of 1 (Resident #8) of 16 sampled residents. The facility further failed to ensure a nurse did not transcribe a medication order to a resident's medication administration record (MAR) that was not prescribed to the resident for 1 (Resident #2) of 16 sampled residents.Findings included:1. A facility policy titled, Significant Change of Condition, effective01/29/2024, indicated, 1. A licensed nurse will assess the patient for signs and symptoms of change of condition. 2. Notify provider and document in Progress Notes.An admission Record indicated the facility admitted Resident #8 on 03/17/2024. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder and delusional disorders.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/19/2025, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had no behavioral symptoms during the assessment period.Resident #8's Care Plan Report included a focus created 04/14/2024 and revised 03/06/2025 that indicated the resident had behaviors of refusal of showers, medications, to be weighed, to go to bed at night, and moved around with their suprapubic catheter above their waist. During an interview on 10/16/2025 at 8:22 AM, the Human Resources (HR) Director stated that on 06/30/2025 Resident #8 became agitated with her, was verbally aggressive, and as she tried to leave, the resident hit her in the mouth. The HR Director indicated the resident would not calm down, so law enforcement was called.During an interview on 10/16/2025 at 9:23 AM, the Assistant Director of Nursing (ADON) stated she did not know if the behavior incident when Resident #8 hit the HR Director was documented in the resident's record, but it should have been documented. The ADON reviewed Resident #8's record and stated the incident was not documented. The ADON stated the incident should have been documented in the progress notes and on a risk management form to be followed up on. The ADON stated the documentation was important to follow up and monitor the resident, to put in interventions, and maybe see a psychiatrist to prevent similar situations. During an interview on 10/16/2025 at 9:50 AM, the Administrator stated the behavior incident with Resident #8 was not documented.During an interview on 10/17/2025 at 4:29 PM, Unit Manager #1 stated Resident #8's verbal altercation with staff on 06/30/2025 should have been documentedDuring an interview on 10/20/2025 at 8:54 AM, the Director of Nursing (DON) stated she did not find any documentation in Resident #8's record regarding the verbal altercation with the HR Director. The DON stated there should have been documentation in the resident's record. The DON stated documentation was important because that was how staff knew what was going on, to be able to monitor and reevaluate to move forward.During a follow-up interview on 10/20/2025 at 9:19 AM, the Administrator stated she expected behaviors to be documented in a resident's record.2. An admission Record indicated the facility readmitted Resident #2 on 10/03/2025. According to the admission Record, the resident had a medical history that included diagnoses of end stage renal disease and surgical aftercare following surgery.Resident #2's Medication Administration Record [MAR] for the timeframe 10/01/2025-10/31/2025, revealed the transcription of an order dated 10/03/2025, for tranexamic acid oral tablet 650 milligram (mg), give one tablet by mouth one time only for blood clot until 10/04/2025. Resident #2's hospital discharge summary with a discharge date of 10/03/2025, did not reveal any documentation to indicate the resident was ordered a one-time dose of tranexamic acid 650 mg. Resident #2's medical record revealed no evidence of a physician's order for a one-time dose of tranexamic acid 650 mg. During an interview on 10/15/2025 at 2:30 PM, the Administrator stated the nurse who transcribed Resident #2's orders did not check the name on the records before they entered (transcribed) the order. During an interview on 10/16/2025 at 8:50 AM, the Director of Nursing (DON) stated when a resident admitted to the facility from a hospital, she expected the nursing staff to review the transfer (discharge) summary to ensure the name and medication orders matched. The DON stated the hospital staff mixed up their records and there was a one-time dose of tranexamic acid prescribed to another patient that ended up being transcribed onto Resident #2's MAR because the nurse did not check the name on the paperwork. During a follow-up interview on 10/20/2025 at 9:19 AM, the Administrator stated there was a transcription error that occurred because the name of the resident's paperwork (discharge summary) wasn't checked before the order was transcribed to Resident #2's MAR.