STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Harbor Post Acute Healthcare Center	200 Civic Avenue Salisbury, MD 21804

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of facility investigation, resident medical records, and interview with facility staff, it was determined that the facility failed to ensure that a resident remained free of verbal abuse. This was evident for 1 (Residents #57) of 6 residents reviewed for abuse.The findings include: On 04/16/2026 at 3:50 PM, a review of facility reported incident # 2726069 was conducted. The review alleged that on 1/15/2026, Staff #40 verbally abused Resident #57. On 04/16/2026 at 3:58 PM, a review of the facility's investigation records indicated that the facility had verified the abuse allegation. The review revealed a witness statement from Staff #21 who heard Staff #40 tell Resident #57, Just come inside, sit down, and shut up. A review of Staff #40 interview statement conducted by the Director of Nursing (DON) revealed that the staff had asked the resident to come inside from the smoking area. Resident #57 stated that they did not want to come, and the staff told the resident to shut up and come inside.On 04/16/2026 at 5:00 PM, an interview with Staff #13, Activities Director, was conducted. She recalled that on the day of the incident, she was notified by Staff #21 that Staff #40 was going back and forth with a resident and told the resident to shut up.On 04/16/2026 at 5:03 PM, an interview with the DON was conducted. She reported that during the facility's investigation, Staff #40 reported that he had words back and forth with Resident #57 and that the staff confirmed that he stated come inside and shut upOn 04/16/2026 at 5:08 PM, the DON was notified that this was a concern.

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review and interviews, it was determined that the facility staff failed to ensure a resident's belongings were secured until the family was able to acquire them. This deficient practice was evidenced in 1 (#239) of 1 record reviewed for misappropriation of property during the recertification survey.The findings include: On 04/15/26 at 1:12 pm the surveyor reviewed the Self Report concerning Resident #239's missing cell phone. The resident transitioned on 03/17/26; when the family went to the facility to pick up the resident's belongings, his/her cell phone was missing. The resident's daughter reported to the Administrator on 03/20/26 at 1:08 pm that the resident's phone was missing. The laundry and the resident's room were searched, and the staff was unable to locate the phone. On 04/15/26 at 1:32 pm a review of a note dated 03/17/26 at 12:16 am indicated the resident passed and the family would come to the facility to collect the resident's belongings. A statement written on 03/19/26 at 7:32 pm by Nurse Supervisor #43 indicated the resident's family went to the facility to look for the resident's phone. When the phone could not be located at the police were notified. On 04/15/26 at 2:37 pm the surveyor read a statement written on 03/16/26 that indicated when Resident #239 passed, GNA #42 took money that was under the pillow to the nurse's station. The money was placed in the Unit Manager's office. On 03/23/26 GNA #30 wrote a statement indicating that on 03/18/26 during the 3 pm-11pm shift they saw the resident's cell phone and placed the phone in a green Bay Harbor bag. The bag was left in the room although the resident passed and was no longer able to use the phone. GNA #31 wrote a note on 03/24/26 indicating they saw the phone on Resident #239's bedside table on 03/17/26 during the 11 pm- 7 am shift. A note was written by RN Unit Manager #6 indicating the family went into the room and there was no phone or charger in the room. On 04/16/26 10:47 am, during a telephone interview with GNA #30 the surveyor asked when a resident passes what do they do with the resident's belongings. GNA #30 verbalized they pack up the belongings and put them behind the nurses' station with the resident's name on the bag. The belongings stay on the unit a day or two before housekeeping takes the belongings downstairs. There is not a place for them to secure the belongings until they are retrieved by the family. They put the residents name on a piece of paper inside the bag. GNA #30 terminated the call before the surveyor could ask further questions. On 04/16/26 at 2:30 pm during a telephone interview with GNA #31 the surveyor asked when Resident #239 passed what they did with the belongings. GNA #31 verbalized they didn't mess with anything because they were not told to do anything; usually the family picks up the belongings. The surveyor asked what the policy is. GNA #31 verbalized they were not sure about the policy, but the other aide should have packed it up. They worked 11pm -7 am; the resident was already gone. On 04/16/26 at 3:30 pm the surveyor reported to Administrator #1 that when Resident #239 transitioned, GNA #30 and GNA #31 saw the resident's cell phone and did not secure the phone. The cell phone was unable to be located, and the facility would be cited for misappropriation of property.

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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 medical record review and interview, facility nursing staff failed 1.) to provide nursing services that did not meet professional standards by failing to correctly identify a resident (resident # 237) prior to medication administration leading to the resident being administered medication prescribed for another resident (resident #244), and 2.) to adhere to nursing care standards of practice as evidenced by a nurse failed to write a verbal order Glucagon after the medication was administered and 3.) failed to document a resident's ostomy care. This deficient practice was evidenced in 4 (# 237, #244, #234, & #236) of 13 medical records reviewed during the recertification survey. 1.) Surveyor review of a complaint (2797325) on 4/13/26 at 9:00am alleging that a member of the facility's nursing staff erroneously administered medications to resident #237 that were prescribed for the resident's former roommate that had discharged earlier in the day. Review of resident # 237's medical records on 4/13/26 at 9:30am revealed a change in condition progress note dated 3/4/26 at 11:30pm stating that the resident was given his/her roommates night-time medication. The resident had no abnormal signs or symptoms from the incorrect medication administration. The resident's provider was contacted and informed of the incident. The provider ordered the resident's vitals to be monitored every 4 hours for 12 hours. Further review of the medical records revealed no adverse symptoms from the incorrect medication administration. Interview with the Director of Nursing (DON) on 4/14/26 at 6:00am revealed resident #237's incorrect medication administration was considered an unusual medical event by the facility. The surveyor asked the DON if the facility reported the incorrect medication administration incident to OHCQ. The DON admitted that the facility failed to report the incident to OHCQ. The surveyor then asked the DON if the facility investigated the root cause of the incorrect medication administration incident. The DON stated the facility investigated the incident and provided the investigation to the surveyor. Review of the incorrect medication administration incident investigation on 4/14/26 at 8:30am revealed CMA #44 failed to verify resident # 237's identity prior to administering medication that was prescribed for resident #244. CMA #44 stated in a statement that he/she administered the medication prescribed for resident #244 without verifying the resident's admission status. Review of resident #244's medical record on 4/14/26 at 9:00am revealed that the resident discharged from the facility on 3/4/24 at approximately 2:00pm. Interview with RN #26 on 4/15/26 at 8:01am revealed that nursing staff that administer medication (RN, LPN, and CMT) are trained to verify resident unit census prior to medication administration pass. Also, each resident receiving medication requires the nursing staff member to verify identity prior to medication administration. The surveyor asked RN #26 about medication reconciliation after a resident discharge. RN #26 stated that nursing staff that are assigned to a medication cart are trained to reconcile resident medications prior their scheduled work shift and when a resident discharges during their scheduled work shift. When a resident discharges during the scheduled work shift, nursing staff assigned to the medication cart is trained to collect all medications not given to the resident and put the medications in the medication room for pharmacy pick-up. The medication should not be available for administration from the medication cart after the resident discharges from the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor informed the DON on 4/14/26 at 11:30am that the incorrect administration incident would be further reviewed by OHCQ for deficient practice. The surveyor informed the Administrator on 4/16/26 at 2:00pm that the incorrect administration incident would be further reviewed by OHCQ for deficient practice. 2.) On 04/13/26 at 10:08 am a review of Resident #236 electronic health record (EHR) revealed the resident was difficult to arouse on 01/02/26 at 11:32 pm and their fingerstick 50 mg/dl. Registered Nurse (RN) #26 gave the resident Glucagon in the resident's left thigh. The note indicated the on-call provider was made aware and a new order to recheck the glucose level in 10 min and give another dose of Glucagon and notify the provider of the results. On 04/13/26 at 3:02 pm the surveyor received a copy of the Health Status Note written by RN #26. The note indicated the on-call provider was made aware of the resident's hypoglycemic episode & Glucagon was given. An order was received to recheck the glucose level in 10 min and give another dose of Glucagon and notify the provider of the results. Further review of the EHR revealed an order was not written for Glucagon x 2 doses nor was a documented follow-up (F/U) fingerstick documented. On 04/14/26 at 7:39 am during an interview with RN#26, they verbalized the orders were received from Synergy's on call provider but was uncertain who they spoke with. During that time, they worked PRN (as needed) but currently she works full time. The resident received one dose of Glucagon and their F/U fingerstick was 88 mg/dl. She/he forgot to write the order. The next nurse was supposed to monitor Resident #236; she/he forgot to write the note that they spoke with the physician and the follow-up fingerstick. On 04/14/26 at 7:54 am during an interview with Director of Nursing (DON) #2, the y verbalized RN #26 should have written an F/U note and pass the information to the next shift. Their provider made a note. She/he should have put the order in and documented the F/U fingerstick. The Unit Managers, DON, and ADON review 24-hour notes, but that note was missed. They would have expected the incident to be entered as a change in condition. 3.) On 04/14/26 at 11:10 am during an interview with RN#37, the surveyor asked did they refuse to change Resident #234 ostomy appliance. RN#37 verbalized they had wound care training about 3 weeks and learned to perform ostomy care as a Certified Nursing Assistant (CNA). They changed Resident #234's ostomy appliance as needed. It was documented in the TAR. The resident had a fold that made the appliance difficult to sticking to the skin. The wound nurse assisted with helping the appliance to stick to the resident's skin. On 04/14/26 at 11:29 am a review of the Resident #234 treatment administration record (TAR) for February 2026 revealed there was no documentation to verify the staff was changing the residents' ostomy appliance or providing ostomy care. On 04/14/26 at 12:38 pm during an interview with RN #38 the surveyor asked if a resident has an ostomy, where is the care provided documented. RN #38 verbalized the care would be documented in the EHR; orders for ostomy care should be on the TAR. When the care was provided it should have been signed off on the TAR. On 04/15/26 at 1:07 pm during an interview with RN Wound Specialist #17 the surveyor reported there (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no documentation in Resident #234 EHR to verify ostomy care was provided. At 1:26 pm RN Wound Specialist provided the surveyor with an order for the resident's colostomy appliance, but they were unable to find documentation the care was being provided.

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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 record reviews and interviews it was determined that the facility administered medication to a resident without clinical indication. This was evident for 1 (Resident #54) out of 9 residents reviewed for medication administration. The findings include: On 04/13/2026 at 12:04 PM, a complaint alleged that Resident #54 was administered Gabapentin (anticonvulsant) without clinical indication. On 04/13/2026 at 12:47 PM, record review revealed that Resident #54 did not have an active or discontinued order of Gabapentin. On 04/13/2026 at 12:50 PM, record review revealed that Resident #54 experienced side effects, including dizziness, following the administration. On 04/14/2026 at 9:27 AM, an interview with the Director of Nursing revealed that the medication error occurred and that the Gabapentin was intended for a different resident. On 04/16/2026 at 10:57 AM, the concerns were addressed with the Nursing Home Administrator and Director of Nursing and they indicated that they understood.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews and record reviews, it was determined that the facility failed to serve residents meals based on their menu tickets. This was evident for 2 residents (Resident #137 and #81) out of 4 residents observed during dining.The findings include: On 04/16/2026 at 1:03 PM, the surveyor observed the meal tray for Resident #137. Meal ticket indicated that the resident was to be served 8 oz of whole milk, however this resident's meal tray did not have milk. On 04/16/2026 at 1:04 PM, a brief interview was conducted with Resident #137. They reported that they did not like the facility's food, and that they looked forward to having milk, because it was the only thing they liked during mealtimes. Resident #137 added that they were not served milk today. Staff #5, Regional Food Service Director, was present during this interview, and confirmed that the resident was not served milk. On 04/16/2026 at 1:08 PM, surveyor and Staff #5, made another observation. Resident #81's meal ticket indicated that the resident should have been served pasta for lunch, however, the resident was served mashed potatoes. On 04/16/2026 at 1:22 PM, an interview with Staff #33, Facility's Food Service Director, was conducted. She reported that the employee at the end of the food line is responsible for ensuring the meal ticket matched what was served. She also acknowledged that residents should be served what is indicated on their meal tickets.On 04/16/2026 at 2:30 PM, the facility administrator was notified of the concern.