

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews, it was determined that the facility staff failed to enter medication orders into a resident's electronic health record (EHR). This deficient practice was evidenced in 1 (R #238) of 5 resident records reviewed for medication administration during the recertification survey. The deficient practice resulted in harm to R#238. The facility implemented effective and thorough corrective measures following this incident and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 3/13/2026. The findings include: On 04/15/26 at 4:05 p.m., a review of the facility's investigation concerning R #238 revealed the resident was discharged from a local hospital on [DATE] and was readmitted to the facility about 12:30 am on 03/07/26. Registered Nurse (RN) #28 was the receiving nurse at the facility and was responsible for completing the admission, which included ensuring the physical assessment was documented and entering the resident's medication orders. On 04/16/26 at 9:55 a.m., a review of R #238's discharge summary revealed the resident was ordered Acetaminophen (Tylenol) 650 mg every (q) 5 hours (hr) PRN (as needed), Eliquis 10 mg by mouth (PO) twice a day (BID) for three 3 days, and 10 other medications. The only medication the resident received was Acetaminophen. Eliquis was the medication prescribed to help prevent the resident's blood from clotting. On 04/16/26 at 11:36 am, during an interview with Director of Nursing #2, she verbalized R #238 came to them on a Friday night a little after midnight; RN #28 was the assigned nurse, and the resident was a readmission. Sunday before lunch, the resident's daughter reported they had leg pain and wanted the resident to go to the hospital. The resident's daughter asked RN #26 about the resident's medications, and it was discovered their admission medication orders were not entered. The resident's previous orders were on the chart, but the new admission orders were not entered. The resident returned to the facility with a new order for Eliquis; three doses of Eliquis were not given because the new medication orders were not entered into the EHR. The resident developed a clot and required a thrombectomy (a medical procedure used to remove a blood clot from a blood vessel). On 04/16/26 at 12:06 pm, during an interview with RN #26, she verbalized R #238 asked for pain medication and they told the medicine aide to give the resident Tylenol. The resident didn't complain of pain any longer. When the resident's daughter came to the facility to visit her parent, they asked if the resident received their pain medication; RN #26 verbalized yes. The daughter named the medication the resident was prescribed, but RN #26 didn't see the medications. There were only two medications on the medication administration record (MAR). When RN #26 read the discharge (DC) summary, they realized the medications were not entered. Nurse Supervisor #39 was made aware of the error and reviewed the medication regimen with the family. Nurse Supervisor #39 administered pain medication to the resident; the resident was reassessed after they received the pain medication. Resident #238 (continued on next page)		

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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Actual harm Residents Affected - Few	daughter requested her parent to be sent back to the hospital. The resident was sent back to the hospital. On 04/16/26 at 4:00 pm a review of R #238's operative note dated 03/08/26 revealed the resident was diagnosed with left lower extremity acute limb threatening ischemia with a recent history of left atrial thrombus (clot) with planned outpatient oral anticoagulation that was not continued after discharge from the hospital. R #238 underwent a left femoral tibial open embolectomy (surgical removal of a clot). On 04/16/26 at 7:07 pm during an interview with RN #28, who was assigned to admit Resident #238, she verbalized that the resident arrived early in the morning and they were unfamiliar with the readmission process. When a resident came back to the facility, they must start the whole process over; he/she thought everything carried over. The surveyor asked RN #28 if they reported to the oncoming nurse that the admission was not complete. RN #28 verbalized not being able to remember everything, but Nurse Supervisor #39 was made aware the admission was not complete. The surveyor asked RN #28 if the standard of practice was to give a report to the oncoming nurse or the supervisor. RN #28 verbalized they must have told the nurse. On 04/16/26 at 7:29 pm the surveyor completed a review of credible evidence to ensure the facility plan of correction was followed. An audit was completed of all new admissions within the past 30 days. The facility initiated a New Admission/readmission Checklist to be completed when every new admission/readmission comes to the facility. Also, the medications are reviewed to ensure the medications are entered into the electronic health record. All licensed nurses were reeducated on the admission process. All licensed nurses were re-educated on the process of completing a 24-hour chart check daily on the 11-7 shift to ensure all new orders for the day. Based on the above actions taken by the facility and verified by surveyors on site, it was determined that the facility's deficient practice was past-noncompliance with a compliance date of 3/13/26.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, resident interview, and record review, and staff interview, it was determined that the facility failed to: 1.) supervise and identify residents needing assistance with smoking and 2.) ensure adequate supervision of residents in wheelchairs. This was evident for 4 (Resident #83, # 8, #47, #68) out of 32 residents reviewed during the recertification survey. 1. The survey team made several observations of residents sharing cigarettes in the designated smoking area from 4/12/26 &ndash; 4/15/26. The survey team requested the smoking policy on 4/12/26 at 1:00pm. Review of the smoking policy on 4/15/26 at 10:00am revealed residents are not permitted to share smoking items including cigarettes with another resident. The survey team interviewed smoking aide #14 on 4/16/26 at 12:30pm regarding smoking policy and his/her responsibilities as a smoking aide. Smoking aide #14 stated that he/she was responsible for monitoring residents in the designated smoking area. Smoking aide #14 admitted that he/she observed residents sharing cigarettes on many occasions. Smoking aide #14 also admitted that he/she failed to intervene when he/she observed residents sharing cigarettes in the designated smoking area. The survey team interviewed Activity Director #13 on 4/16/26 at 2:00pm regarding responsibilities and training of the smoking monitors. Activity Director #13 stated that the smoking monitors were trained to ensure that the facility smoking policy is adhered to by the residents. Smoking monitors are also responsible for informing nursing staff of policy violations by residents to ensure that smoking evaluations and any smoking privileges match the resident's status. The survey team interviewed the Director of Nursing (DON) regarding residents sharing cigarettes. The DON stated that he/she was aware that residents shared cigarettes. The survey team asked the DON if the facility placed the residents violating facility smoking policy on an improvement plan and the DON admitted that the facility failed to place the violation of smoking policy on an improvement plan. 2. The survey team made several observations of ambulatory residents pushing wheelchair bound residents without foot rests from 4/12/26 &ndash; 4/15/26. Several residents stated that facility staff will not push wheelchair bound residents without a foot rest. The survey team interviewed the Director of Nursing (DON) on 4/16/26 at 1:30pm regarding ambulatory residents pushing residents without foot rests. The DON confirmed that facility staff are trained to only push wheelchair residents with a foot rest. The survey team stated that they observed several ambulatory residents pushing wheelchair bound residents without foot rests. The DON stated that he/she was aware that ambulatory residents were pushing wheelchair bound residents without foot rests. The DON also stated that ambulatory residents are counseled about the safety concerns of (continued on next page)		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pushing wheelchair bound residents without foot rests. The DON further stated that the ambulatory residents continue the action and .we can't tell residents what to do. 3. On 4/14/2026 at 9:45 AM, a review of Resident #83's record was conducted. The smoking evaluation from 4/19/2024 stated that Resident #83 did not smoke. The most recent smoking evaluation of 3/24/26 stated that Resident #83 does not smoke. According to the resident record, the resident's Brief Interview for Mental Status score is 15 and the resident was a quadriplegic. A BIMS (Brief Interview for Mental Status) score is a 0&ndash;15 rating used in long-term care to assess cognitive function, focusing on orientation, memory, and recall. It is mandatory for nursing home admissions to track cognitive health. Higher scores indicate better cognitive function, with scores of 13-15 representing normal memory and 0-7 indicating severe impairment. On 4/14/2026 at 10:52 AM, an interview with Resident #83 was conducted. Resident #83 stated that they go out to smoke during the daytime. Resident #83 stated that they ask other residents for cigarettes because they don't have any. When asked if the staff member outside that supervises them is okay with them asking other residents for cigarettes and smoking out there, Resident #83 stated, yes. When asked who was out supervising when they are smoking, the resident stated that usually Staff #14 or another activities staff member is out with them. On 4/14/2026 at 11:08 AM, an interview was conducted with the Director of Nursing (DON). When asked if nursing was aware that Resident #83 had recently started smoking, the DON stated that they were not aware. On 4/15/2026 at 9:58 AM, an interview with Staff #14 was conducted. When asked what is done when they notice anybody with new limitations, Staff #14 stated that they notify their boss. When asked if they have seen Resident #83 smoking outside, Staff #14 stated they have seen Resident #83 out there once or twice. When asked if it was common for residents to request cigarettes from other residents, Staff #14 stated, yes. On 4/15/2026 at 1:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the Resident #83was evaluated yesterday (4/14/2026) after the survey team made them aware. The DON stated that the facility was not providing a list of current smokers to the activities staff prior to surveyor intervention. The DON stated that the activities staff were educated to make the nursing staff aware of anybody that is a new smoker or needs to be evaluated. 4. On 04/13/2026 at 10:22 AM, an interview with Resident #8 was conducted. They reported that they fell yesterday because another resident was pushing their wheelchair too fast. When asked why another resident was pushing them on the wheelchair, the resident stated that the facility staff had been told not to push residents on wheelchairs if a resident did not have footrests on. On 04/14/2026 at 4:20 AM, another surveyor observed Resident #47 pushing Resident #68 who was in a wheelchair without footrests. On 04/15/2026 at 9:14 AM, while conducting an observation of the facility's smoking designated area, (continued on next page)		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the surveyor observed 3 other residents who were pushing residents in wheelchairs. On 04/15/2026 at 9:15 AM, an interview with Staff #21 was conducted. When asked if residents pushed other residents who were in wheelchairs, the staff stated that it occurred often because the facility staff had been trained not to push a resident on a wheelchair without footrests on. On 04/15/2026 at 1:23 PM, an interview with the Director of Nursing (DON) was conducted. She reported that the facility staff was trained and asked not to push residents if they had no footrest on the wheelchair. The DON also reported that there was no evidence that residents were educated on safe wheelchair use or instructed not to push other residents. The surveyor requested a copy of the education training that was provided to staff. On 04/16/2026 at 10:02 AM, the DON reported that she could not find the training education that was provided to the staff. At this time, the surveyor notified the DON of the supervision concerns.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and observations, it was determined that the facility failed to ensure that the smoking designated area was safe for residents who used wheelchairs. This was evident during a tour of the smoking designated area. The findings include: On 04/13/2026 at 10:22 AM, an interview with Resident #8 was conducted. They reported that residents who use wheelchairs to access the smoking area had a difficult time because the ramp is crooked and wheelchairs get stuck causing residents to fall. On 04/15/2026 at 9:04 AM, the surveyor toured the designated smoking area for residents. An inclined ramp was noted that leads to a gazebo and several uneven surface areas. On 04/15/2026 at 9:14 AM, an interview with Staff #21 was conducted. She reported that residents who are in wheelchairs had a hard time getting over the door seal to go over the ramp. She also reported that the door closes too fast which caused problems for residents and that she had witnessed several residents' wheelchairs [NAME] off the paved pathway and resulted to falls. At this time, Staff #21 pointed to an uneven surface area and stated, that's where the wheelchairs get stuck. When asked if she had reported these safety concerns to the administrator, she stated that she had reported them to her supervisor. On 04/15/2026 at 09:27 AM, an interview with Staff #35 was conducted. He reported that residents get stuck on the ramp often, he also reported that he had witnessed residents get hit by the door several times. He clarified that the doors to the smoking area opened slowly but closed too fast. On 04/15/2026 at 1:23 PM, an interview with the Director of Nursing (DON) was conducted. She reported that the facility has had a couple of fall incidents that happened in the smoking designated area, but no one had reported that residents were being hit by the door because it closed too fast. On 04/15/2026 at 1:46 PM, the DON was made aware of the safety concerns.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 observations and staff interview, it was determined that the facility failed to maintain a homelike environment. This was evident for 1 (Resident #83) out of 57 residents reviewed for environment. The findings include: On 4/14/2026 at 5:36 AM, an observation of Resident #83's room was conducted. Resident's nightstand drawer front was detached and placed inside of drawer. On 4/14/2026 at 9:14 AM, an interview was conducted with the Director of Nursing (DON). This surveyor showed the DON Resident #83's broken drawer. The DON stated they would take care of the drawer. On 4/14/2026 at 11:12 AM, an observation of Resident #83's room was conducted. The drawer was repaired after surveyor intervention.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 up. On 04/16/2026 at 5:08 PM, the DON was notified that this was a concern.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interview, it was determined that the facility failed to provide the resident or representative with the required discharge documentation. This was evident for 1 (Resident #230) out of 2 residents reviewed for hospitalizations. The findings include: On 4/16/2026 at 12:09 PM, a review of Resident #230's records was conducted. According to a nursing note on 3/15/2026 at 5:12 PM, the resident was sent to the hospital on 3/15/2026. The note stated that the resident's sibling was notified. Upon further investigation, the resident's profile stated that the resident was their own representative. On 4/16/2026 at 12:30 PM, an interview with the Director of Nursing (DON) was conducted. This surveyor requested evidence of written notification of discharge and bed hold notification that was provided to the resident or representative. The DON stated that the facility notifies the family and residents verbally of transfer. This surveyor referred the DON to the requirement of notifying the resident or their representative in writing of the reason for transfer. DON stated that they would look to see if the facility notified the resident or representative in writing and if the bed hold policy was provided. On 4/16/2026 at 1:01 PM, the DON confirmed that the resident or representative was not provided a written reason of transfer to hospital nor evidence that the bed hold policy was provided to the resident or representative.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and staff interview, it was determined that the facility failed to complete Minimum Data Set Assessments accurately. This was evident for 2 (Resident #15 and #28) out of 8 residents reviewed in the Resident Assessment task. The findings include: The Minimum Data Set (MDS) is a federally mandated, standardized clinical assessment tool used in Medicare/Medicaid-certified nursing homes to measure the health status, functional capabilities, and care needs of residents. On 4/17/2026 at 8:52 AM, a review of Resident #15's record. The resident's MDS assessment conducted on 3/4/2026 indicated in Section N0415 that Resident #15 did not receive Antipsychotics. According to the resident's February and March Medication Administration Record in 2026, the resident received Olanzapine, an antipsychotic, every day in February and March. On 4/17/2026 at 8:58 AM, a review of Resident #28's record was conducted. The resident's admission MDS assessment from 3/3/2026 indicated in Section M0100 that the resident did not have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device, and indicated in Section M0300 that the resident had a Stage 3 unhealed pressure ulcer. According to Resident #28's admission Screening Skin assessment, the resident had a stage 3 pressure ulcer on admission. On 4/17/2026 at 9:21 AM, an interview with the MDS Coordinator (Staff #41) was conducted. This surveyor reviewed Resident #15's MDS with Staff #41. Staff #41 stated that Resident #15's MDS section N was completed incorrectly. Staff #41 stated that the resident should have been marked yes to taking Antipsychotics in Section N0415. This surveyor reviewed Resident #28's MDS with Staff #41. Staff #41 stated that Resident #28's admission Section M0100 was checked No to Pressure wound on bony prominence in error. Staff #41 stated that they will amend the MDS assessments to ensure they are accurate.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 (continued on next page)		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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' (continued on next page)		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interviews and record reviews, it was determined that the facility failed to provide showers to dependent residents. This was evident for 2 (Resident #243 and #56) out of 10 residents reviewed for activities of daily living during the recertification survey. The findings include: 1.) On 04/13/2026 at 9:29 AM, an interview with Resident #243 was conducted. They reported that they had not had a shower in a long time. They added that they wanted to shower at least once a week. On 04/14/2026 at 6:03 AM, a review of Resident #243's record indicated that they were scheduled to shower Monday and Thursdays 3pm to 11pm. The review of the care plan failed to reveal that the resident had refused showers but indicated that the resident was dependent on staff for showers. On 04/15/2026 at 11:26 AM, a review of the electronic records of shower refusal was compared to the shower sheets. Staff #34 had signed most of the shower sheets as resident refused including 4/6/2026. A review of Staff #34 work schedule was conducted. There was no evidence of a time punch and according to the schedule, Staff #34 was off on 4/6/26. 2.) On 04/13/2026 at 9:58 AM, an interview with Resident #56 was conducted. They reported that they had not been offered a shower for several months. On 04/14/2026 at 5:51 AM, a review of Resident #56's medical record was conducted. The review of the shower task indicated that the resident was dependent on staff for showers. The resident was scheduled to shower on Tuesdays and Fridays. Review of the shower sheets for the month of March and April 2026 revealed that the resident refused showers and only had a shower once 3/24/26. However, the resident's care plan did not include a care plan for shower refusal. Upon further review of the shower sheets, the surveyor noted that Staff #34 had documented shower refusals on all the shifts. A review of Staff #34 schedule was conducted. The review indicated that the staff marked resident refused showers even though Resident #56 was not part of his assigned unit. The Director of Nursing (DON) was notified of the inconsistencies in shower documentation. On 04/15/2026 at 3:55 PM, an interview with Staff #34 was conducted. He confirmed that he was off on 4/6/2026. He also acknowledged that at the end of the shift he signed off the showers as refused without offering residents a shower opportunity. Staff confirmed that he had not offered showers to Resident #243 or Resident #56 in April. On 04/16/2026 at 9:32 AM, an interview with the DON was conducted. At this time the shower sheets and the electronic documentations were reviewed again. The DON confirmed that there are inconsistencies with documentation. Additionally, the DON reported that she had a conversation with Staff #34 who confirmed that he never offered residents a shower and instead marked off the task as refused.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 and record review, it was determined that the facility failed to administer medications to residents in accordance with minimum standards of care. This was evident for 3 Resident (Resident #237, #244, and #242) of 3 reviewed for insulin medication administration during the annual 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. 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 04/12/2026 at 1:20 PM, during an interview with Resident #242, the resident stated, I do get insulin, but it seems like I am always getting it late. On 04/15/2026 at 7:24 AM, record review revealed a physician order for HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Sliding Scale insulin. The order instructed administration subcutaneously before meals and at bedtime. The order specified administration times of 6:30 AM, 11:30 AM, 4:30 PM, and 10:00 PM. (continued on next page)		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/2026 at 7:28 AM, review of the medication administration record and audit report for Resident #242 for the period of 3/31/2026 through 4/14/2026 revealed ten (10) instances of late insulin administration as follows: On 4/3/2026, insulin due at 11:30 AM was administered at 12:44 PM. On 4/7/2026, insulin due at 11:30 AM was administered at 12:40 PM. On 4/8/2026, insulin due at 11:30 AM was administered at 1:07 PM. On 4/13/2026, insulin due at 11:30 AM was administered at 1:31 PM. On 3/31/2026, insulin due at 4:30 PM was administered at 7:11 PM. On 4/1/2026, insulin due at 4:30 PM was administered at 5:31 PM. On 4/3/2026, insulin due at 4:30 PM was administered at 6:03 PM. On 4/6/2026, insulin due at 4:30 PM was administered at 5:39 PM. On 4/8/2026, insulin due at 4:30 PM was administered at 6:08 PM. On 4/13/2026, insulin due at 4:30 PM was administered at 6:35 PM. On 04/15/2026 at 7:37 AM, review of Resident #242's blood glucose summary revealed blood glucose monitoring was performed and documented in concurrence with the times insulin was administered. On 04/15/2026 at 11:29 AM, during an interview with Registered Nurse (Staff #38), she stated insulin administration times for sliding scale insulin before meals are 6:30 AM, 11:30 AM, and 4:30 PM, with bedtime insulin scheduled for 10:00 PM. She also stated insulin may be administered within one hour before or one hour after the scheduled time, and administration beyond one hour after the scheduled time is considered late. On 04/17/2026 at 7:15 AM, during an interview with the Director of Nursing (DON), the DON stated insulin administration for sliding scale insulin is typically administered before meals and at bedtime. The DON stated fingerstick blood glucose checks are obtained and insulin is administered prior to meal tray delivery. The DON confirmed nurses are expected to administer insulin within one hour before or one hour after the scheduled time, and administration beyond this window is considered late. The DON was made aware of the concern at the time of interview.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interviews and record reviews, it was determined that the facility failed to change a resident's foley catheter as ordered. This was evident for 1 (Resident #71) out of 3 residents reviewed for urinary tract infection during the recertification survey. The findings include: A Foley catheter is a thin, flexible, sterile tube inserted into the bladder to drain urine into a collection bag when a person cannot urinate on their own, or to keep the bladder empty. On 04/13/2026 at 9:21 AM, an interview with Resident #71 was conducted. They reported that the facility does not change their foley catheter as often as they are supposed to. On 04/14/2026 at 9:53 AM, a review of Resident #71's medical records was conducted. The review revealed an active order to change the foley catheter every 28 days and as needed for blockage. Further review of the records indicated that the resident's foley catheter was changed on 4/6/2026 by Staff #39, wound care nurse. On 04/14/2026 at 10:15 AM, a follow up interview with Resident #71 was conducted. They reported that no one had changed their catheter in April. On 04/14/2026 at 10:39 AM, an interview with Staff #39 was conducted. When asked if she remembered changing Resident #71's foley catheter, staff stated that she had not changed any resident's foley catheter in April. She also confirmed that she marked the task as completed without changing the foley. On 04/14/2026 at 11:15 AM, the unit manager and Director of Nursing were made aware of the concern.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 record reviews and interviews it was determined that the facility failed to ensure complete and accurate dialysis orders were present for residents receiving dialysis services. This was evident for 1 (Resident #223) out of 1 residents reviewed for dialysis. The findings include: On 04/13/2026 at 9:47 AM, Resident #223's record review failed to reveal an active dialysis order. On 04/14/2026 at 6:28 AM, an interview with the Director of Nursing revealed that residents receiving dialysis are expected to have active dialysis orders in place. On 04/16/2026 at 10:57 AM, the concerns were brought up to the Director of Nursing and Nursing Home Administrator and they indicated that they understood.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of Geriatric Nursing Assistant personnel files and interviews it was determined that the facility failed to conduct yearly performance reviews at least every 12 months on 1 (Staff #24) out of 5 personnel files reviewed. The findings include: On 04/15/2026 at 3:00 PM, a review of Geriatric Nursing Assistant (Staff #24) personnel files revealed that there was no yearly evaluation in the personnel files. On 04/16/2026 at 10:35 AM, an interview with the Nursing Home Administrator revealed that she was unable to locate it. 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.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interviews, observations and review of records, it was determined that the facility failed to provide routine dental services to residents. This was evident for 2 (Resident #56 and #9) out of 3 residents reviewed for dental services during the annual survey. The findings include:1.) On 04/13/2026 at 10:02 AM, an interview with Resident #56 was conducted. They reported that they had seen a dentist a while ago but was unsure when the follow-up was because the facility had not communicated. On 04/14/2026 at 10:58 AM, a review of Resident #56's medical records failed to reveal any dental notes or evaluations. The Director of Nursing (DON) was asked to provide dental assessments for the resident. On 04/14/2026 at 11:27 AM, an interview with the DON was conducted. She reported that she could not find any notes that indicated Resident #56 had been seen for routine dental evaluation. The only note available was an oral assessment completed when the resident was admitted into the facility. On 04/15/2026 at 10:10 AM, during a follow up interview, the DON confirmed that the resident had not been seen by dental services since 2024 and that the resident qualified to be seen by health drive for routine dental services. 2.) On 04/13/2026 at 10:34 AM, an interview with Resident #9 was conducted. They reported that they used to wear dentures and had not seen a dentist for about 2 years. The surveyor observed that the resident had a chipped tooth. On 04/14/2026 at 10:58 AM, a review of Resident #9's medical record was conducted. The review failed to reveal any dental evaluations or notes. On 04/14/2026 at 11:27 AM, an interview with the DON was conducted. She confirmed that the only oral evaluation completed was during the resident's nursing admission assessment. On 04/15/2026 at 10:17 AM a brief follow-up interview with the DON was conducted. She confirmed that Resident #9 had not received any routine dental services. She reported that she was unsure why because the resident qualified for routine dental services through health-drive. During this interview, the surveyor notified the DON of the dental concerns.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(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 medical record review and interview, facility nursing staff falsely documented medication administration to a resident (resident #244) when the medication was given to another resident (resident #237). This was evident in 1 of 8 residents reviewed; and failed to document when a resident who had wounds was repositioned to offload pressure. This was evidenced in 1 (#236) of 2 resident records reviewed with wounds during the recertification survey. Findings include: 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. Further review of the medical records revealed no adverse symptoms from the incorrect medication administration. Additional review of the resident's medication administration record revealed no record of the incorrect medication administration on 3/4/26 Interview with the Director of Nursing (DON) on 4/14/26 at 6:00am confirmed Resident #237's incorrect medication administration. The surveyor 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. Further review of resident #244's medical record revealed medication administration documented administration of the following medications at 2200 (10PM): 750 mg Methocarbamol 40 mg Lipitor 0.25 ropiniol 81 mg asprin 60mg Cymbalta (continued on next page)		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(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	25mg metoprolol 40mg protonix 500mg x2 bactrim 400mg x2 gabapentin 2. On 04/13/26 at 9:15 am a review of Resident #236 electronic health record (EHR) revealed during the resident's admission they had a wound on their right heel, (R) ischial, and sacrum. The surveyor checked the Task section to verify the resident was being turned to offload pressure; there was no documentation to verify the resident was being repositioned. On 04/13/26 at 10:34 am a review of Resident #236's MDS assessment review date (ARD) 12/12/25 Section GG0170 the resident required substantial maximum assistance with rolling to the left & right. The resident did not have the ability to roll from lying on back to the left and right side and return to lying on back in bed. On 04/13/26 at 10:48 am during an interview with LPN #27 the surveyor asked how often did the staff reposition a resident who was unable to turn independently and where was that documented? The nurse verbalized the typically go into the residents' room every two hours to reposition them; it's not documented anywhere for the nurses. On 04/13/26 at 10:49 am during an interview with GNA # 16 they verbalized when they need to turn a resident they would get a co-worker to assist or use the draw sheet to change the resident's position and they used to be able to document it in the Task Section in PointClickCare but now there is no place to document that it was done. On 04/13/26 at 10:50 am RN Unit Manager #6 reported if a resident had a wound they would have an air mattress. A wound Stage 3 or higher the resident would have an air mattress that rotates on a 20-minute cycle. The GNA's check them and offload pressure with pillows and documentation should be on the Kardex.		

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and staff interview, it was determined that the facility failed to follow appropriate infection control practices while providing care. This was evident in 4 (Resident #14, #83, #240, and #196) out of 61 residents reviewed for infection control. Enhanced Barrier Precautions (EBP) are an infection control strategy for nursing homes, requiring gowns and gloves during high-contact resident care to prevent the spread of multidrug-resistant organisms. 1.) On 4/13/2026 at 6:47 AM, an observation of Resident #14 was made. The resident had a tracheostomy and an Enhanced Barrier precaution sign outside their door. On 4/13/2026 at 8:51 AM an observation of care provided to Resident #14 by Staff #37 was conducted. Staff #37 performed trach care with gloves but did not use an isolation gown. On 4/16/2026 at 4:19 PM, an interview was conducted with the Infection Preventionist (Staff #3). When asked if they were aware of the infection control concerns observed by the survey team, Staff #3 stated that she was made aware of all of the concerns and has educated all staff in the facility and complete teachable moments with specific staff members who displayed improper use of Enhanced Barrier Precautions. 2.) On 04/12/2026 at 11:53 AM, during the initial tour of the facility, Resident #196, who had a peripherally inserted central catheter (PICC line) and a wound vacuum device, had signage posted outside of the resident's room indicating Enhanced Barrier Precautions (EBP). During the observation, a Registered Nurse (Staff #37) entered the resident's room and did not don a gown while performing a blood glucose check. On 04/12/2026 at 12:01 PM, during an interview with the RN (Staff #37), She stated that she should have had a gown on when providing direct care with a resident on EBP, which included obtaining the blood glucose finger stick for that resident. 3.) On 4/12/2027 at 12:06 PM, during an interview with Resident #240, they stated that they were diagnosed with Clostridioides difficile (C-Diff) on 4/11/2026. The precaution signage posted outside the resident's room indicated Enhanced Barrier Precautions rather than Contact Precautions, which are required for residents with active C. diff infection per current infection control standards. During the observation, at the same time, a visitor was present in the room and was noted to be wearing gloves but not wearing a gown while in direct contact with the resident's environment. On 4/12/2026 at 12:31 PM, during an interview with Staff #3, the Infection Preventionist, she confirmed that Resident #240 was diagnosed with C-Diff on 4/11/2026. She confirmed that when a resident has C-Diff they require Contact precautions. She further stated that everyone that goes in and out of the room, including staff and visitors, were required to wear isolation gowns and gloves. She confirmed that the wrong signage was posted outside of the door and after surveyor intervention, the sign was changed. 4.) On 04/14/2026 at 4:24 AM, during unit observation, surveyor observed Staff #36, providing a bed (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 Bay Harbor Post Acute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bath to Resident #83. On the resident's door, there was a sign that indicated the resident was on Enhanced Barrier Precautions (EBP). On 04/14/2026 at 4:28 AM, a review of Resident #83's records was conducted. The review revealed an active EBP precautions order. On 04/14/2026 at 5:06 AM, an interview with Staff #36 was conducted. When asked why the staff was not wearing the indicated Personal Protective Equipment (PPE), a gown and gloves, Staff #36 replied, nobody uses the PPE. On 04/14/2026 at 5:10 AM, an interview with Resident #83 was conducted. They reported that the facility staff does not wear the appropriate PPE when providing direct care to them. On 04/14/2026 at 5:42 AM, the Director of Nursing was notified of the concern.		