| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215083 | A. Building<br>B. Wing | 10/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Caroline Nursing and Rehab | 520 Kerr Avenue<br>Denton, MD 21629 |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined that the facility failed to ensure the discharge of a resident was documented in the medical record that included the resident's status at the time of discharge and the reason for the discharge. This was identified for 1 (Resident #12) of 3 residents reviewed for discharge during the complaint survey.The findings include:On 10/27/2025 at 12:30 PM a review of Resident #12's medical record revealed: A Transfer/Discharge Report that include Resident #12's information of an admission date of 11/11/2023 and a discharge date of 09/23/2025 for transfer/discharge to an acute care hospital. However, further review of Resident #12's medical record revealed no indication of Resident's status or the reason for the transfer/discharge to the hospital. On 10/27/2025 at 1:25 PM during an interview, Staff #4 Registered Nurse (RN) stated if a resident had a change in condition, an assessment would be completed. An EInteract Change in Condition form is completed, the physician is notified, and all actions are documented in the progress notes of the Electronic medical record.On 10/28/2025 at 8:35 AM during an interview, the Director of Nursing (DON) stated that when a resident is transferred to the hospital, the nurse completes an EInteract form, and a physician order would be obtained.On 10/28/2025 at 12:26 PM the DON verified there was no documentation or Physician order for Resident #12's change in condition that resulted in him/her being transferred to the hospital on [DATE]. At this time the DON was made aware of the 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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on the investigation of complaints, reviews of medical records, and interviews with staff, it was determined that the facility failed to 1) appropriately manage narcotic medications, and 2) give medications as ordered by a Physician. This was evident for 4 (Resident #4, #8, #9, and #12) of 14 residents reviewed during the complaint survey. The findings include:<br><br>Controlled substances must be dispensed and administered exactly as prescribed by an authorized practitioner. Any alteration (e.g., changing dose form, splitting, compounding, or storing unused portions) must comply with federal law and institutional policy. [U.S Drug Enforcement Administration (DEA) Diversion Control Division-21 CFR part 1301 and 1304 ]<br><br>Controlled substances shall not be pre-drawn, pre-split, or pre-prepared for later administration. Any partial tablet prepared for a single dose and not administered must be immediately and properly wasted. [State Nursing and Pharmacy Boards]<br><br>1) A portion of the investigation for complaint #2575219, conducted on 10/27/25 at 10:12 AM, revealed that Resident #4 had a prescribed medication for pain, Oxycodone 15mg every 8 hours, from 7/18/25 to 7/28/25. The order was changed on 7/29/25 at 11:59 PM to Oxycodone 15mg, give 7.5mg by mouth every 8 hours for pain.<br><br>On 10/27/25 around 10:30 AM, a review of the Medication Administration Record (MAR) for July 2025 revealed that Oxycodone 7.5mg was administered on 7/30/25 at 1:37 PM and 10:03 PM, and on 7/31/25 at 8 AM and 2 PM.<br><br>The surveyor reviewed Resident #4's controlled drug sheet for Oxycodone 15mg on 10/27/25 at 11 AM. The review revealed a handwritten statement on the top left side that read: Dosage is 7.5mg cut in half and waste other half if needed per NP 7/30/25. It also recorded medication administration on 7/30/25 at 1:37 PM and 10:03 PM, and on 7/31/25 at 8 AM and 2 PM, all with a half dose of the tablet. However, there was no documentation for wasted doses on 7/30/25 and 7/31/25.<br><br>In an interview with Staff #1 (Licensed Practical Nurse) on 10/27/25 at 1:03 PM, she stated, If a narcotic medication has a score line, we can split it. But it must be discarded with two nurses. We can't keep the remaining dose.<br><br>On 10/29/25 at 11:06 AM, the surveyor reviewed the policy and procedure named Controlled Substance Administration & Accountability. The policy stated that when the dosage form dispensed is larger than the dose, the total dose administered and that portion destroyed is documented to show the total disposition of the drug.<br><br>Also, on 10/29/25 at 11:08 AM, in an interview with Staff #8 (Vice President of Clinical Services), she confirmed that nurses should not be splitting narcotics. She said, If they needed to, the remaining half of it should be destroyed with two nurses' signatures.<br><br>During the exit conference with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 10/29/25 at 11:15 AM, the surveyor shared the above concern. The DON and NHA validated the concern.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2a) On 10/27/2025 at 9:45 AM, review of Resident #8's medical record revealed the following: A Physician's order dated 09/03/2025 on the medication administration record for Calcium Citrate Oral (Calcium Citrate is a mineral that plays an important role in building strong bones and maintaining heart health.) tablet to give one tablet by mouth 2 times a day. However, further review of the Medication Administration record, Calcium Citrate was documented as 9 (see nurses notes) 16 times throughout the month of September.<br><br>On 10/27/2025 at 9:45 AM, continued review of the nurse's progress notes for the month of September indicated Nurses notes documented for the Calcium Citrate as medication not here. There was no evidence that indicated that the Pharmacy, or a Physician was notified about the unavailable medication.<br><br>On 10/27/2025 at 9:45 AM, the surveyor reviewed a Physician order dated 09/03/2025 on the medication administration record for Listerine Mouth/Throat Liquid (Mouthwashes) to give 15 milliliters (ml) by mouth three times a day for Dry Mouth. However, further review of the Medication administration records the Listerine Mouthwash was documented as, 9 (see nurses note) 26 times for the month of September.<br><br>On 10/27/2025 at 9:45 AM, continued review of the nurse's progress notes for the month of September indicated Nurses notes documented for the Listerine as medication unavailable. There was no evidence that indicated Pharmacy, or a Physician was notified about the unavailable medication.<br><br>On 10/27/2025 at 9:45 AM, the surveyor reviewed a Physician's order dated 09/18/2025 on the medication administration record for Potassium Chloride Tablet Extended Release to give 1 tablet orally two times a day for Low potassium. However, further review of the Medication Administration record revealed the Potassium was documented as 9 (see nurses Notes) 2 times for the month of September.<br><br>On 10/27/2025 at 9:45 AM, Continued review of the nurse's progress notes for the month of September indicated Nurses notes documented for the Potassium as medication unavailable. There was no evidence that indicated Pharmacy, or a Physician was notified about the unavailable medication.<br><br>2b) On 10/27/2025 at 10:45 AM, a review of Resident #9's medical record revealed the following: A Physician's order dated 09/08/2025 on the medication administration record for Trelegy Ellipta Inhalation Aerosol Powder (a medication used to improve lung function and breathing) to take 1 puff inhaled orally one time a day for Chronic Obstructive Pulmonary Disease (COPD) which is a lung disease that cause airflow obstruction and breathing difficulties. However further review of the medication administration record revealed from 09/08/2025 through 09/13/2025 was documented as 9 (see Nurses note) for those 6 days.<br><br>On 10/27/2025 at 10:45 AM, continued review of the nurse's progress notes for the month of September indicated that nurse's notes were documented for the Trelegy as medication unavailable. There was no evidence that indicated Pharmacy, or a Physician was notified about the unavailable medication.<br><br>2c) On 10/27/2025 at 12:30 PM a review of Resident #12's medical record revealed the following: A Physician's order dated 11/15/2023 on the medication administration record for Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids) Give 1 tablet by mouth one time a day related to Cerebrovascular disease (a health condition that affect the blood vessels in the brain) documented 9 (see nurse notes) from September 15, 2025 through September 23rd, 2025 a total of 8 days.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/27/2025 at 12:30 PM, continued review of the nurse's progress notes for the month of September indicated that nurse's notes were documented for the Fish Oil as medication unavailable. There was no evidence that indicated Pharmacy, or a Physician was notified about the unavailable medication.<br><br>On 10/27/2025 at 1:20 PM during an interview, Staff #3 Certified Medication Aide (CMA) stated that if a medication is unavailable, she documents in the electronic medical record the medication is unavailable and informs the nurse.<br><br>On 10/27/2025 at 1:25 PM during an interview, Staff # 4 Registered Nurse (RN) stated if a medication is unavailable, the Pharmacy must be contacted to ascertain the medication's delivery status. The Physician should be notified for an alternative medication, and the Omnicell (a backup system for nurses to retrieve medication) should be checked. Notification to both the Physician and Pharmacy is required on the first day of the medication's unavailability.<br><br>On 10/28/2025 at 8:35 AM, during an interview with the Director of Nursing (DON) stated that if a medication is unavailable, the pharmacy would be contacted for a refill, or the backup system would be used to obtain the medication. Nurses would contact the Physician if a medication were on backorder. The Director of Nursing (DON) was informed of concerns at this time. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on review of Intakes, medical record review, and staff interview it was determined that the facility failed to 1) properly monitor a resident's status after a significant medication error, 2) Notify the physician before withholding a medication used to regulate blood sugar, and 3) ensure that a resident's medications were administered as ordered. This was evident for 2 (Resident #13 and #4) of 2 residents reviewed for medication administration during this complaint survey. The findings include:<br><br>Insulin is used to regulate blood sugar levels.<br><br>According to the American Diabetes Association, fast acting insulin begins to work about 15 minutes after injection, peaks in about one or two hours after injection, and lasts between two to four hours. Long-acting insulin takes 6 hours to reach the bloodstream, has no peak, and is effective for 36 hours or more.<br><br>1) On 10/27/2025 at 9:00 AM in review of Intake # 2634348, an anonymous source, expressed concerns related to medication errors.<br><br>On 10/27/2025 at 11:20 AM, a review of the facility incident log provided by the Director of Nursing (DON) revealed a medication error dated 08/19/2025 at 7:40 AM.<br><br>On 10/27/2025 at 11:40 AM, a review of the medication error investigation provided by the DON revealed, during breakfast, the training nurse administered 10 units of fast-acting insulin that was not needed instead of the scheduled long-acting insulin.<br><br>On 10/27/2025 at 2:50 PM, a review of Resident #13's medical record revealed the following: on 08/19/2025 at 07:52 AM a progress note that indicated new orders were received to continue to monitor blood sugars every 15 minutes until Resident #13 was transferred out for an office visit. However, there was no evidence of a Physician order in Resident #13's medical record for the monitoring of blood sugar.<br><br>On 10/27/2025 at 2:50 PM, further review of Resident #13's medical record revealed blood sugar levels were documented on 08/19/2025, at the following intervals:<br><br>-8:16 AM (24 minutes after the previous reading)<br><br>-8:45 AM (29 minutes after the previous reading)<br><br>-9:20 AM (35 minutes after the previous reading)<br><br>-10:09 AM (49 minutes after the previous reading)<br><br>On 08/19/2025 at 11:51 AM a progress note for Insulin Lispro (fast acting insulin) sliding scale with a notation Patient out of facility for provider appointment.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/28/2025 at 8:30 AM during an interview, the Assistant Director of Nursing stated that he had made the medication error on 08/19/2025 with Resident #13. He informed the Nurse Practitioner and initiated blood sugar monitoring. He couldn't recall if the ordered 15-minute blood sugar monitoring period was 2 or 3 hours but acknowledged he should have placed the order in the Electronic medical record. He documented the blood sugar monitoring in the vital signs section of the electronic medical record. He confirmed that blood sugars were not being monitored every 15 minutes following the insulin medication error.<br><br>On 10/28/2025 at 8:45 AM during an interview, the Director of Nursing stated that if a physician ordered blood sugar monitoring every 15 minutes, such an order should be documented in the medical record<br><br>2) On 08/26/2025 at 11:56 AM a progress note for Resident #13 indicated that Insulin Glargine (a long-acting insulin), 10 units once daily, was held due to low morning glucose. However, a review of Resident #13's medical records showed no evidence of physician notification or Physician order to hold the Insulin Glargine for low blood sugar.<br><br>On 10/28/2025 at 8:45 AM during an interview, the Director of Nursing indicated that if a nurse were to withhold scheduled insulin, he would expect a physician's order and notification to the physician.<br><br>3) A portion of the investigation for complaint #2575219, conducted on 10/27/25 at 10:12 AM, revealed that Resident #4 had a prescribed medication for pain, Oxycodone 15mg every 8 hours, from 7/18/25 to 7/28/25. The order was changed to Oxycodone 5mg every 6 hours as needed, starting on 7/29/25.<br><br>On 10/27/25 around 10:30 AM, a review of the Medication Administration Record (MAR) for Resident #4 for July 2025 revealed that Oxycodone 5mg was administered on 7/29/25 at 00:37 AM and 07:15 AM.<br><br>However, a further review of Resident #4's controlled drug record for Oxycodone 15mg showed that the resident was dispensed the Oxycodone 15mg tablet on 7/29/25 at 00:37 AM and 7:15 AM. There was no additional controlled drug sheet for the Oxycodone 5mg dose that was ordered.<br><br>During an interview with the Director of Nursing (DON) on 10/27/25 at 12:21 PM, the surveyor reviewed Resident #4's medical record with the DON. The DON verified that Resident #4 did not have medical records supporting the administration of Oxycodone 5mg. He confirmed that, per the medical records, Resident #4 received Oxycodone 15mg on 7/29/25 instead of the ordered 5mg of Oxycodone. The surveyor shared concern with the DON that Resident #4 received the wrong dose of Oxycodone on 7/29/25. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on the investigation of complaints, record review, and staff interviews, it was determined that the facility staff failed to document the administration of medication in a resident's Medication Administration Record (MAR). This was evident for one (Resident #4) of the four residents reviewed for medication administration during the complaint survey.The findings include:A portion of the investigation for complaint #2575219, conducted on 10/27/25 at 10:12 AM, revealed that Resident #4 received Narcan (naloxone), a life-saving drug that can reverse an opioid overdose, on 7/29/25 due to a lethargic condition.A further review of Resident #4's progress note revealed that Staff #19 (Registered Nurse) documented on 7/29/25 at 1 PM: This nurse has made the clinical decision to Narcan resident once. However, there was no documentation for the medication in the MAR.During an interview with Staff #1 (Registered Nurse) on 10/27/25 at 1:03 PM, she stated that a resident who received Narcan should be documented in both the MAR and the progress note.In an interview with the Director of Nursing (DON) on 10/29/25 around 1 PM, the surveyor shared the concern that the facility staff did not document Resident #4's Narcan administration. The DON validated the concern. |