STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interviews and record review, it was determined that the facility failed to ensure that residents received their meals at a safe and palatable temperature. This deficient practice has the potential to affect all residents. During an initial tour of the facility on 3/16/26, several residents reported that the facility's food was typically cold for hot foods. A review of the facility's food service temperature logs for January 2026 was conducted on 3/17/26 at 2:02 PM. The review revealed missing internal cooking temperatures for: lunch and dinner on 1/4/26, lunch and dinner on 1/5/26, dinner on 1/6/26, lunch and dinner on 1/7/26, lunch and dinner on 1/8/26, lunch and dinner on 1/9/26, lunch and dinner on 1/10/26, lunch and dinner on 1/11/26, lunch and dinner on 1/12/26, lunch and dinner on 1/13/26, lunch and dinner on 1/14/26, lunch and dinner on 1/15/26, lunch and dinner on 1/16/26, dinner on 1/19/26, dinner on 1/20/26, dinner on 1/21/26, dinner on 1/22/26, lunch and dinner on 1/23/26, lunch and dinner on 1/24/26, lunch and dinner on 1/25/26, lunch and dinner on 1/26/26, dinner on 1/27/26, dinner on 1/28/26, and breakfast, lunch, and dinner on 1/30/26, as well as lunch and dinner on 1/31/26.The review also lacked documentation for the holding and serving temperatures for breakfast on 1/8/26, 1/9/26, 1/15/26, and 1/16/26. A random review of the holding temperatures for Lunch and Dinner on the Memory Care, Rehab, 2nd, and 3rd floor units showed the following: seasoned potato wedges at 129 degrees F on 2/3/26; lemon butter angel hair at 125 degrees F on 2/6/26; mashed potatoes at 115 degrees F and chicken alfredo with broccoli at 126 degrees F on 2/7/26; grilled ham and cheese sandwich at 119 degrees F; no recorded holding temperature for dinner on 2/15/26; lasagna at 120 degrees F on 2/17/26; beef strongnoff at 128 degrees F & Egg noodles at 133 degrees F on 2/21/26; sweet and spicy glazed chicken stir-fry at 117 degrees F on 2/22/26; and fish sticks at 129 degrees F on 2/26/26.A review of the facility's policy titled food safety management system noted that cold foods must be held and served at a temperature of 40 F or below and Hot foods must be held and served at a temperature of 140 F or above. However, an earlier review revealed that some hot foods were served below 135 F.During an interview on 3/17/26 at 2:32 PM, staff #17, the dietary general manager, stated that the cooks were expected to check internal food temperatures to ensure safety, and that servers were also responsible for checking the holding temperatures of each meal before service. If the reading was below the acceptable temperature, they were to reheat the food before serving it to residents. Staff #17 confirmed that holding and serving temperatures were missing from the log for some days.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interviews, it was determined that the facility failed to treat residents with respect and dignity, as evidenced by failing to knock and request permission before entering residents' rooms. This was evident for 1 (Resident #75) of 1 resident reviewed for dignity. The findings include:An observation was made during an interview on 3/16/26 at 12:28 PM with the representative of Resident #75 in the resident's room. Staff #3 and #4, both nursing assistants, entered the resident's room with a lunch tray. The observation did not show that both staff members knocked or announced their entry, and waited for permission before entering the resident's room. In a later interview on 3/16/26 at 12:35 PM, both staff #3 and #4 confirmed they did not knock on Resident #75's door before entering and added that they should have done so. During an interview on 3/19/26 at 9:45 AM, the Assistant Director of Nursing stated that she expected her staff to knock on residents' doors or announce their presence before entering residents' rooms if their hands were full.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADLs) received showers. This was evident for 1 (Resident #2) of 1 resident reviewed for ADLs. The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to collect information on each Resident's strengths and needs. This information informs Resident care planning decisions.An interview with Resident #2 on 3/17/26 at 7:58 AM indicated that there were a few showers, and they did not happen regularly. A review of Resident #2's MDS assessment dated [DATE] indicated that the Resident was completely dependent on staff for assistance with showers. A further review of the shower schedule for the unit where Resident #2 lived showed that he/she was scheduled for 2 showers per week, totaling 8 showers per month.Further review of the GNA (Geriatric Nurse Assistant) shower documentation for Resident #2 from January 1 to January 23, 2026, and from February 1 to February 28, 2026, was completed. The review revealed that between January 1-23, 2026, Resident #2 received four partial baths (washing a resident in bed with a basin of water, soap, and a washcloth without washing the hair and usually focusing on cleaning the face, underarms, hands, and perineal area) on days he/she was scheduled for showers. Additionally, three partial baths were recorded in February. The review did not show any evidence that Resident #2 received showers in January or February 2026.During an interview on 3/20/26 at 10:32 AM, staff #9, a Unit manager, reviewed Resident #2's GNA shower documentation for January 1-23, 2026, and February 1-28, 2026, with the surveyor. The interview lacked supporting evidence that Resident #2 received showers on the days she was scheduled to have them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure residents with or at risk of developing pressure ulcer/injuries receive appropriate services for treatment and prevention. This was evident for 2 (Resident #10 and #108) of 3 residents reviewed for pressure injuries. The findings include:1) Review of Resident #10's medical record revealed the resident was admitted to the facility in December 2025. The resident was seen weekly by a wound specialist for the treatment of pressure ulcers and skin tears. One of the pressure ulcers was a stage IV ulcer to the left heel. A stage IV pressure ulcer involves full-thickness skin and tissue loss with exposed or directly palpable muscle or bone in the ulcer. 1a)There was an order, in effect from 2/4/26 until it was discontinued on 2/18/26, to clean the left heel stage IV ulcer with normal saline, apply mupirocin ointment and cover with a dressing every day and evening shift. Mupirocin ointment is a medication that treats skin infections caused by bacteria. Review of the Medication Administration Record (MAR) for February 2026 revealed an area for staff to document that the dressing to the left heel was completed. Nursing staff documented a 9 on the following occasions when the dressing change was due:-2/6 evening-2/7 day-2/9 day-2/10 evening-2/11 day-2/15 evening Review of the chart codes revealed a '9' indicates 'other/see nurse notes', indicating the dressing change was not completed on those six occasions. Review of the nursing note failed to reveal documentation as to why the dressing changes were not performed on these occasions. These notes were just a repeat of the actual dressing change order. On 3/18/26 at 2:15 PM Nurse #14 confirmed that a '9' indicates the dressing change was not completed for some reason and to see the nursing notes. Surveyor reviewed the concern that the nursing notes just repeated the order. Nurse #14 then proceeded to check the nursing notes, then stated,you're right, just repeats the order, should have said why not completed. On 3/18/26 at 3:39 PM surveyor reviewed the above dates with the ADON #15 and that the corresponding notes just re-iterate the order, and that no documentation was found to indicate why the dressing change had not occurred on these occasions. As of time of survey exit on 3/20/26 at 4:00 PM no additional documentation was provided to indicate the dressing change was completed as ordered for the six occasions identified in February. 1b) On 3/18/26 review of Resident #10's medical record revealed the wound specialist saw the resident on 3/11/26. This note revealed that Bacterial Fluorescence Imaging showed bacteria in the periwound area of the left heel wound. The note included a recommendation for changing the dressing to alginate calcium with silver once daily and as needed. Silver has antibacterial properties. On 3/18/26 further review of the medical record revealed the current order, in effect since 2/18/26, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the left heel was to clean with normal saline, apply plurogel and cover with border dressing every day shift. Plurogel assists with maintaining a moist wound healing environment. Further review of the medical record failed to reveal documentation to indicate the 3/11/26 recommended change to the dressing order was implemented or addressed with the primary care physician. On 3/18/26 at 3:56 PM interview with Nurse #16 revealed that she attends rounds with the wound specialist. The wound specialist makes recommendations verbally, which Nurse #16 writes down, and then the wound specialist also puts the recommendations into her note. Nurse #16 reported that at the end of rounds she (Nurse #16) puts the orders into the system. Nurse #16 confirmed that what is written in the wound specialist note would be translated into an order. Surveyor then reviewed the 3/11/26 wound specialist note which included a recommendation that the dressing be changed to silver alginate, but review of the orders failed to reveal documentation to indicate the order was changed. Nurse #16 then asked,that's not [his/her] current order? And went on to state there were some problems with the wound specialist's notes last week and indicated that she missed the order change. On 3/20/26 at 3:20 PM surveyor reveiwed the concern with the ADON regarding the failure to ensure wound specialist orders were implemented. 2) Resident #108 had been Residing in the facility since 2009. Current diagnosis included but was not limited to dementia, hemiplegia and hemiparesis following a stroke affecting the left side. Hemiplegia is a severe form of paralysis affecting one side of the body while Hemiparesis is weakness or reduced movement on one side of the body. On 3/16/26 at 12:02 pm, Resident #108 was observed laying in bed equipped with an air mattress. A control box by the foot of the bed indicated that the air mattress was set to 4 bars for firmness with static pressure. On 3/17/26 at 9:32 AM, the resident was again observed in bed, and the air mattress setting remained the same. Resident #108's medical record was reviewed on 3/17/26 at 11:36 AM. The review revealed an assessment dated [DATE] that indicated the resident was at 'high risk' of developing pressure ulcer/injuries. The review also revealed the air mattress order that indicated the setting should be on 3 bars for firmness with alternating pressure on a 15-minute cycle. This order was scheduled every shift for the nurse to monitor for proper function and inflation. A subsequent review of Resident #108's medical record was conducted on 3/17/26 at 3:38 PM. The review revealed the order for proper function and inflation (that indicated the specific air mattress setting) was signed by the day shift nurse for 3/17/26. However, immediately after this review, on 3/17/26 at 3:39 PM, the resident was again observed in bed with the air mattress still set at 4 bars for firmness with static pressure. On 3/17/26 at 3:46 PM, the evening shift nurse (Nurse #8) confirmed the observation of Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#108's air mattress setting and indicated that the bed previously had an audible alarm/beep, but she was not sure what was wrong with it. The findings were discussed with the Unit Manager (Staff #6) on 3/17/26 at 3:50 PM. A review of Resident #108's air mattress order was conducted with Staff #6 and she confirmed that it should be on alternating pressure at 3 bars for firmness. Staff #6 indicated that she wanted to see the control box herself and asked the surveyor to accompany her to the resident's room. On 3/17/26 at 3:55 PM, Nurse #8 was observed in Resident #108's room, in the process of changing the air mattress setting. As the mattress was set to the correct setting, the control box started to beep/alarm. Both Nurse #8 and Staff #6 confirmed that the mattress was holding air but did not know why it was beeping and indicated that may be the reason someone had changed the setting. The concern was discussed with Staff #6 that nurses are signing the order but failed to ensure the resident's air mattress was functioning and inflated appropriately. Staff #6 reported that she was putting in a maintenance request to check Resident #108's air mattress immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, medical record review, and interview it was determined that the facility failed to maintain a medication error rate of less than 5%. This was based on 2 errors out of 32 opportunities for error during the medication observation task and involved 2 (Resident #179 and #53) out of the 3 resident's observed. The findings include: 1) On 3/19/26 at 9:14 AM surveyor observed nurse #12 prepare and administer medications to Resident #179. Several of the medications prepared were packaged in a sealed white bag which included the name, dosage and quantity of the medications in the bag. Additionally, each of the medications in the white bag were individually packed with identifying information. The nurse proceeded to pop the pills out of the individual containers into a medicine cup. Surveyor retained the white bag and the individual pill containers after the nurse was finished with them and prior to disposal. During the observation Nurse #12 reported Allopurinol 100 mg was one of the medications. Prior to entering the resident's room surveyor and the nurse counted the number of pills in the cup. The total number of pills was 14, which included 13 different medications, one of which the dosage required two pills. Surveyor noted at this time that one of the tablets was only half a pill. Nurse #12 was not sure which medication was the half a tablet, indicating she had not noticed as she was popping them out of the packaging. After administering the medication to the resident Nurse #12 signed off on the Medication Administration Record that 13 medications were administered, including Allopurinol 100 mg. After the observation, review of Resident #179's medical record revealed the resident had an order, in effect from 3/12/26 until it was discontinued on 3/18/26, for Allopurinol Oral Tablet 100 mg Give 0.5 tablet by mouth one time a day. This order indicated that staff would administer a half tablet of this medication. Further review, of both the white bag and the individual package of the Allopurinol, revealed written underneath Allopurinol TAB 100 MG was (0.50x100MG=50 MG). Thus, indicating this was the half tablet observed during the medication pass. Further review of the medical record revealed a new order, dated 3/18/26 for Allopurinol Oral Tablet 100 mg give 1 tablet by mouth one time a day. On 3/19/26 at 10:42 AM after reviewing the packaging with the surveyor, Nurse #12 confirmed the Allopurinol was the half tab and that she gave 50 mg. After confirming the new order was for Allopurinol 100 mg Nurse #12 indicated she would give the resident another 50 mg to give the full dose. On 3/19/26 at 11:00 AM surveyor provided the packaging of the Allopurinol to the Assistant Director of Nursing (ADON #15) and asked what the dosage was. The ADON stated: 100 mg. Surveyor then asked the ADON to read the packaging again, at which time the ADON stated: 50 mg. Surveyor then reviewed the medication error related to the wrong dose being administered due to recent change in the order to 100 mg. 2) On 3/20/26 at 8:21 AM surveyor observed Nurse #13 prepare and administer medication to Resident #53. Nurse #13 accessed a container of Reguloid powder and proceeded to use a small plastic spoon to obtain one spoonful of the powder which was placed in a small drink cup. When surveyor asked how much powder was being used, Nurse #13 responded, one teaspoon. Water was added to the powder, and the nurse reported it was 120 ml of water. The nurse administered the Reguloid to the resident. Reguloid is psyilium fiber used to treat constipation. Metamucil is also psyilium fiber used to treat constipation. After the observation surveyor reviewed resident #53's medical record and found an order for Metamucil give 1 Tablespoon by mouth one time a day for constipation. There are three teaspoons in a tablespoon. On 3/20/26 at 11:09 AM surveyor asked ADON #15 how they expect staff to measure out a powder. ADON indicated she would need to check on that and would get back to the surveyor. On 3/20/26 at 11:42 AM the ADON reported that staff should be using the medicine cup to measure powders. Surveyor reviewed the concern that the nurse did not use a measuring cup and that the nurse had reported he was giving a teaspoon, but the order is for a tablespoon. The ADON reported she had spoken with Nurse #13 and was aware that the nurse did not use the measuring cup. On 3/20/26 at 1:46 PM: Nurse #13 acknowledged that he only gave a teaspoon rather than a tablespoon and stated, I misread the order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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, record reviews, and interviews, it was determined that the facility failed to serve residents meals according to a predetermined menu that reflected their preferences. This was evident in 2 out of 3 dining observations during the survey. The findings include:1)While observing the second-floor unit tray line on 3/18/26 at 11:51 AM, the surveyor requested a test tray. The tray contained a meal ticket for Resident #38, which listed the following food items to be served: pureed bread, pureed mandarin oranges, magic cup (a fortified nutritional frozen dessert designed for individuals needing extra calories and protein), pureed Salisbury steak, gravy, cheddar mashed potatoes, and pureed summer squash and carrot medley. However, ongoing observation did not reveal that Resident #38's tray contained pureed bread, pureed mandarin oranges, and a magic cup. In an interview with the Dietary General Manager on 3/18/26 at 12:51 PM, he reported that the facility was out of Magic Cup, and it was replaced with regular ice cream for the Resident. During a subsequent interview with the Registered dietitian on 3/18/26 at 1:36 PM, she reported that Resident #38 was to receive a magic cup during lunch for malnutrition. She added that it had more calories than ice cream and expected it to be provided to the Resident daily at lunch.2) A breakfast observation on 3/19/26 at 8:17 AM on the 2nd floor, Unit showed Resident #5 eating breakfast in his/her room. On the Resident's meal tray was a ticket listing all the food items: Smart Balance buttery spread, double chocolate chip muffin, fresh banana, cranberry juice, orange juice, and scrambled eggs.However, continued observation failed to show that Resident #5's tray included a double-chocolate chip muffin and a fresh banana. Staff #19, a speech therapist, was in the resident's room and confirmed that resident #5 did not receive a fresh banana with his/her breakfast tray. The double chocolate chip muffin was replaced with a plain muffin.3) An observation of breakfast on 3/19/26 at 8:25 AM included Resident #114, eating in his/her room. The observation noted from the Resident's meal ticket was that s/he was to receive grits, Smart Balance buttery spread, orange juice, pancakes, and turkey sausage. However, the observation did not show that Resident #114 received grits on his/her tray. In an interview on 3/19/26 at 8:49 AM, staff #19 confirmed that Resident #114 was missing grits from his/her breakfast tray.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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 record review, observation and interviews, it was determined that the facility failed to ensure medical orders were put in correctly and the nurses documented accurate administration of oxygen use. This was evident for 1 (Resident #15) of 5 resident reviewed for respiratory care. The findings include:Resident #15 was admitted into the facility in late 2019. Current diagnosis included but was not limited to respiratory failure with hypoxia.Hypoxia is a critical condition where body tissues are deprived of adequate oxygen, causing symptoms like shortness of breath, confusion, headaches, and rapid heart rate. Treatment involves oxygen therapy and addressing the underlying cause.On 3/16/26 at 11:46 AM, Resident #15 was observed sitting on the wheelchair watching TV in his/her room. Oxygen was on flowing at a rate of 2 L/min connected to a nasal cannula. However, the nasal cannula was not on the resident and was observed coiled up on the resident's bed.A review of Resident #15's medical record was conducted on 3/17/26 at 3:21 PM. The review revealed the order for oxygen to be administered continuously at 2 l/min every shift with a start date of 12/30/25. The review also revealed interventions in the care plan for oxygen to be administered 2 L/min continuously at bedtime initiated on 9/24/25, and as needed related to shortness of breath that was initiated on 6/29/20. There was no documentation found in the care plan to indicate that oxygen was to be administered continuously every shift.Resident #15 was interviewed about his/her oxygen use on 3/17/26 at 3:30 PM. The resident answered, only at night, when asked when s/he puts on the nasal cannula for oxygen administration.On another observation of Resident #15 on 3/18/26 at 1:09 PM. The resident was sitting in room watching TV with no oxygen being administered. Immediately after the observation, Resident #15's administration record was reviewed and revealed that the day shift nurse (Nurse #10) had signed off the order that oxygen was administered continuously for day shift on 3/18/26.On 3/18/26 at 1:12 PM, Nurse #10 was interviewed regarding Resident #15's oxygen use. Nurse #10 stated, S/he's on 2 Liters of oxygen when in bed. During the day, s/he's not on oxygen. When asked about the resident's order for oxygen, he indicated he was not sure and would have to review it on the computer. Upon reviewing the resident's medical record, he confirmed that the order was for continuous administration and that he had signed this order for his shift. Nurse #10 stated, I guess I wasn't paying attention. He also reported that the resident goes around the unit with a wheelchair with no oxygen tank/no oxygen use.In an interview with the Assistant Director of Nursing (Staff #15) on 3/19/26 at 9:50 AM, the finding above was discussed and she indicated that it was already discussed with her by the nursing staff. Staff #15 reported that Resident #15 was hospitalized in December of 2025 and when the resident returned to the facility, the oxygen order was put in as continuous rather than as needed. The concern was discussed that nurses are signing the administration record for the oxygen as being administered continuously since 12/20/25 every shift but confirmed that the resident only utilized oxygen at bedtime. Staff #15 verbalized understanding and acknowledged the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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 record observations, record reviews and interviews, it was determined that the facility failed to ensure staff donned appropriate personal protective equipment (PPE) for residents on enhanced barrier precautions (EBP). This was evident for 2 (Residents #121 and #75) of 7 residents reviewed for infection control and for 1 (Resident #116) of 2 residents reviewed for urinary catheters/UTI. The findings include:Enhanced Barrier Precautions are infection-control measures designed to decrease the spread of infections in nursing homes. They involve wearing gowns and gloves during high-contact resident care activities such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting for residents with infections or colonization of MDROs (multi-drug-resistant organisms), central lines, urinary catheters, feeding tubes, tracheostomies, or any skin openings that need dressing. A gastrostomy tube (G-tube) is a tube inserted into the stomach through an opening in the stomach wall. It is used to deliver medications, liquids, and liquid food. A tracheostomy is an opening (stoma) in the neck that connects directly to the trachea, providing an airway for patients with breathing problems. 1) A review of Resident #121's medical record showed that he/she had a G-tube feeding tube and a tracheostomy. An observation on 3/16/26 at 10:13 AM noted signage on Resident #121's door indicating the resident was on EBP, which required wearing gowns and gloves during high-contact resident care activities. Continued observation showed a cart filled with PPE supplies placed outside Resident #121's room. Further observation on 3/16/26 at 10:22 AM showed Staff #5, a registered nurse in Resident #121's room, providing oral hygiene to Resident #121. Staff #5 was noted with gloves; however, she did not wear a gown. The surveyor questioned the staff about the Resident's G-tube feeding at that time. Staff #5 reported that she had just turned it off and flushed it with water before providing oral care. Staff #5 confirmed that she did not wear a gown before performing either task for Resident #121. During an interview on 3/16/26 at 2:34 PM, staff #5 was asked what the EBP signage on Resident #121's door meant. She explained that it indicated to wear gloves, and since Resident #121 did not have an active infection, there was no need to wear gowns. 2) An observation on 3/16/26 at 12:06 PM showed signage on Resident #75's door that indicated that the Resident was on EBP precautions, which meant staff were required to wear gowns and gloves during high-contact Resident care activities. The observation also noted PPE in a cart at the door of the Resident's room. Continued observation noted staff #5 in Resident #75's room performing a dressing change on the Resident's G-Tube site. Staff #5 wore gloves and a mask, but the observation did not show that she wore a gown. In an interview on 3/16/26 at approximately 2:40 PM, staff #5 stated that she did not fully understand the meaning of the EBP signage on Resident #75's door. An interview with the Infection Preventionist Nurse on 3/19/26 at 7:24 AM indicated that all staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

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	members were expected to know what EBP means and which PPE to wear when providing direct care activities to Residents, as training had been provided. 3) Resident #116 was admitted into the facility in mid-2025 with diagnosis that included urinary retention and encounter for fitting and adjustment of urinary device. During an observation of the resident on 3/16/26 at 11:34 AM, the resident indicated that s/he had a urinary catheter. A urine collection bag was secured on the resident's bed frame, supply of gloves was available by the doorway in the resident's room, but there were no available gowns in or outside the room. There was also no signage found to indicate that the resident was on EBP. A review of Resident #116's medical record on 3/17/26 at 9:20 AM revealed an order for EBP that was indicated for urinary catheter with a start date of 9/6/25. On 3/17/26 at 4:04 PM, A geriatric nursing assistant (GNA #7) was observed transferring Resident #116 and reported that she was about to give the resident a shower. GNA #7 was wearing a pair of gloves but did not have a gown on. The findings above were discussed with the nurse unit manager (Staff #6) on 3/17/26 at 4:10 PM. Staff #6 confirmed that Resident #116 was on EBP due to the use of urinary catheter and indicated that she would get the EBP signage and PPE supplies for the resident's room. On 3/17/26 at 4:13 PM, Staff #6 confirmed there was no signage found in or outside Resident #116's room. At this time, GNA #7 stepped out of the resident's room as she needed to get supplies for the resident. GNA #7 confirmed that she was not wearing a gown and indicated that it was because none was available. Staff #6 explained to GNA #7 that gowns and gloves are required to be worn when conducting high contact activities (including transferring, showering, and bathing) with the resident. The facility's infection preventionist nurse (Staff #11) was interviewed on 3/18/26 at 12:04 PM. Staff #11 reported the facility's process when a resident is put on EBP. She noted that other than the medical order and signage, the EBP information would also be in the Kardex (Kardex was explained as a GNA's tool to reference resident medical information including special precautions like EBP). She also reported that putting up the signage on the resident's door and installing the PPE supply station was primarily her responsibility, but the unit managers and weekend supervisors also had access to the materials needed. The concern was discussed with Staff #11 that Resident #116 did not have a signage for EBP, PPE supplies not readily available for staff to use, and GNA #7 was observed conducting high contact activities with the resident without the appropriate PPE. Staff #11 reported that GNA #7 was not a new employee and that a recent staff training on infection control including EBP was conducted in February 2026, where GNA #7 had also attended. Staff #11 indicated that she would reeducate GNA #7 when she returns to work and acknowledged the concern.