STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215111	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurelwood Healthcare Center	100 Laurel Drive Elkton, MD 21921

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 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to provide individual closet space that keeps a resident's clothing separate from their roommates. This was found to be evident in all double occupancy rooms in the facility.The findings include:On 1/29/2026 at 10:20 AM, License Practical Nurse (LPN) #7 was interviewed regarding resident furniture in rooms. LPN #7 stated that in double occupancy rooms, residents share one large dresser that has 5 drawers, each resident gets their own side table with 2 drawers, and both residents share one closet.On 01/29/2026 at 10:53 AM, observations of double occupancy rooms 120, 128, 215, 221, 225, 228, and 229 revealed that there was no physical separation of items in the room closet shared by residents. On 01/29/2026 at 10:59 AM, an interview was conducted with Resident #16 in room [ROOM NUMBER]. Resident #16 stated that they shared the closet space with their roommate. No partition was noted inside the closet to separate roommates' belongings. Resident #16 stated they would not mind having a process in place to separate roommate belongings in the closet.On 01/29/2026 at 11:05 AM, concern about the lack of private closet space for residents was addressed with the Nursing Home Administrator.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on medical record review and facility staff interview, the facility staff failed to protect and value a resident's right to religious freedom (residents #18, 40, 43, 81, 83, and 91). This was evident for 6 out of residents reviewed for resident rights during a recertification survey.The findings include: Review of complaint # 2676017 on 1/19/26 at 10:30am revealed a complaint from a eucharistic minister stating that he/she was unable to provide communion to Catholic residents because the facility has failed to provide the eucharistic minister with an accurate list of Catholic residents for approximately 2 years. Interview with eucharistic minister # 25 on 1/20/25 at 10:17am revealed eucharistic minister attempted to obtain an accurate list of Catholic residents since October 2025. Eucharistic minister #25 normally sends an email to the Administrator and the Activity Director approximately 4 days before he/she will visit the facility. Since March 2025, eucharistic minister #25 alleged that he/she has not recieved an accurate list of Catholic residents so he/she has been unable to provide communion to these residents. Eurcharistic minister #25 also alleged that he/she contacted the Administrator about the unability to receive an accuate list of Catholic residents from the facility. The Administrator was alleged to have stated that he/she saw the email but he/she did not believe that the list of Catholic residents was unimportant at the time of review. On 1/20/26 at 10:45am, the surveyor interview Activity Director #2 regarding the list of Catholic residents. Activity Director #2 provided the surveyor with a copy of the list. Review of the list of Catholic residents on 1/20/26 at 11:30am revealed the list was inaccurate. Comparing the list of Catholic residents with the most recent annual activity preference forms revealed residents #18, 40, 43, 81, 83, and 91 did not indicate that they were Catholic. All of the most recent activity preference forms were signed and reviewed by Activity Director #2. Interview with Activity Director #2 on 1/21/26 at 10:30am revealed that all residents receive an assessment of their activity preferences when admitted , when there are any changes to activity preferences, at re-admission and annually. The surveyor asked when the list of Catholic residents is updated. Activity Director #2 stated that the list of Catholic residents is updated based on any changes to the activity preference form. The Surveyor pointed out that he/she found inaccurate information on the list of Catholic residents. Activity Director #2 stated that his/her assistants normally update the list of Catholic residents as necessary. The surveyor provided copies of the most recent annual activity preference form for resident's #18, 40, 43, 81, 83, and 91. Activity Director #2 reviewed the forms and admitted that the list of Catholic residents was inaccurate. During an interview with the Director of Nursing and the Administrator on 1/21/26 at 11:15am, the surveyor informed the DON and the Administrator that the list of Catholic residents was inaccurate based on the most recent activity preference form. The Administrator stated that the list of Catholic residents would be updated. On 1/21/26 at 12:30pm, Activity Director #2 provided the surveyor with a new list of Catholic residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation and staff interviews, it was determined that the facility failed to ensure a safe, homelike environment as evidenced by multiple sliding closet doors being broken and not being able to close properly. This was found to be evident in rooms 120, 128, 215, 221, 225, 228, and 229.The findings include:On 1/29/2026 at 10:53 AM, a tour of the facility revealed sliding closet doors were used in resident rooms. In rooms 120, 128, 215, 221, 225, 228, and 229, the closet doors were observed to no longer be attached to the top tracks that would allow the doors to open and close properly. Multiple closet doors in these rooms were observed to be prop up against the inside walls of the closets.On 01/29/2026 at 11:05 AM, the rooms were toured with the Maintenance Director (MD) and the Nursing Home Administrator (NHA). The MD stated the facility often must repair closet doors because they currently do not have bottom tracks and often get hit by equipment like wheelchairs that knock them off the top tracks. Surveyor concern with closet doors was addressed with the NHA at this time.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observations and staff interview, it was determined that the facility failed to ensure staffing information was complete and was not missing information. This was evident for 2 out of 2 units observed during the recertification survey. The findings include: On 1/29/2026 at 9:01 AM, an observation of the nurse staffing boards in both units was made. Staffing boards on both units had the accurate date, Facility Name, and Census. There were no actual hours worked for either Nurses or Nursing Assistant on either of the boards.On 1/29/2026 at 9:14 AM, an interview with the Director of Nursing (DON) was conducted. This surveyor made the DON aware of the nurse staff postings not having the hours worked for nursing staff. The DON stated that they will address the boards and was not aware of the requirement.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and interviews, it was determined that the facility failed to ensure that a resident was free from a significant medication error. This was evident for 1 (#343957) of 7 complaints reviewed during an annual survey.The findings include:On 01/22/2026 at 11:06 AM, review of anonymous complaint #343957 revealed that Resident #27 was sent to the hospital following the administration of an incorrect methadone dose.Methadone is a medication used to treat addiction to controlled, strong pain medications. Taking too much or not as ordered can result in overdose which can cause life-threatening symptoms such as slow or irregular breathing, extreme sleepiness, and confusion.On 01/23/2026 at 8:44 AM, an interview with the Director of Nursing confirm the incident did occur to Resident #27. She indicated that the resident was ordered two separate dose amounts for the morning and evening administration (a larger dose in the morning), and that the resident received the morning dose in the evening. She further indicated it was an agency Licensed Vocational Nurse (LVN) who made the error. At the same time, the Director of Nursing indicated she put a new process in place immediately following the incident which required two nurses to sign off on the administration of the medication to ensure that the dose would be administered as ordered, and to prevent the incident from happening in the future. The surveyor requested further information regarding the incident investigation. On 01/23/2026 at 11:55 AM, the surveyor received the incident investigation which revealed the resident was ordered 123mg of Methadone HCl Oral Concentrate in the morning and 45mg of Methadone HCl Oral Concentrate in the evening. Further review of the investigation revealed LVN, Staff #26 administered 123mg of Methadone HCl Oral Concentrate to Resident #27 in the evening instead of the ordered 45mg. The medication error was identified during the resident's methadone medication count at approximately 11pm during shift change on 12/29/2024 due to an incorrect amount of methadone left. At the same time, further review of the investigation revealed that the resident was noted to be breathing slow. The provider was notified of the incident and ordered Narcan (a life saving medication which can reverse taking too much of strong controlled drugs/medications) which was administered. Shortly after, the resident was noted to be breathing at a more normal rate. The resident was sent to the hospital for further evaluation.On 01/23/2026 at 12:11 PM, the surveyor reviewed the concern regarding the significant medication error regarding the incorrect methadone dose administered to Resident #27 and she indicated that she understood and agreed it was a concern.