STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215121	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snow Hill Rehabilitation & Healthcare Center	430 West Market Street Snow Hill, MD 21863

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on reviews of facility reported incident and staff interview, it was determined the facility staff failed to immediately report an allegation of suspected resident abuse to the local police. This was evident for 1 (Resident #3) of 6 residents reviewed during a complaint survey. The findings include: On 09/05/25 the Office of Health Care Quality received a facility reported incident concerning allegations that on Sunday 08/31/25 a nursing staff member (LPN#1) told Resident #3 nursing staff to not to provide care and that S/he was not going to administer any pain medication to Resident #3. The Office of Health Care Quality (OHCQ) is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse are to be reported to the Office of Healthcare Quality and the local police in a timely manner. A review of the facility investigation into the allegation of abuse on 02/03/26 revealed a 5-day follow-up investigation report that indicated Resident #3's responsible party alleged Resident #3 informed his/her family that the nursing staff had not medicated Resident #3 with pain medication. The facility conclusion to the investigation was unsubstantiated and that Resident #3 received was provided care on 08/31/25 and that Resident #3 received pain medication as ordered. The facility investigation also indicated that Resident #3's BIMS score was documented as 13/15 on 06/10/25. A review of the facility Abuse policy on 02/03/36 revealed that the facility will report all instances of alleged or suspected abuse, including verbal and mental abuse, neglect, suspicious injuries of unknown origin, exploitation, and misappropriation of resident property. Investigation and Reporting steps include: Notifying the administrator of any unusual situations in the facility, whether reportable or not immediately, the administrator or designee will report to the State Agency and all other required agencies according to regulations, and nursing and the physician will examine the alleged victim for any signs of injury, including a physical exam and/or psychosocial assessment if needed. Further review of the facility follow-up investigation indicated that the facility did not report this allegation of abuse to law enforcement or any other state agencies. In an interview with the facility administrator on 02/04/26 at 2 pm during the exit conference, the facility administrator confirmed that law enforcement was not notified of the allegation of abuse of Resident #3 on 08/31/25.

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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(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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of a closed and active clinical record and administrative records, and staff interviews, it was determined that the facility nursing staff failed to follow the physician's specific pulse and blood pressure parameters before administering cardiac medications. This was evident for 2 (Resident #1, Resident #3) of 6 residents reviewed during a complaint survey, The findings include: 1) On 01/03/26 the Office of Health Care Quality received a complaint with concerns about resident safety and the quality of care being provided to Resident #1. Review of Resident #1's clinical record on 02/02/26 revealed that Resident #1 was admitted to the facility on [DATE] and had been deemed incapable of making all medical decisions by 2 physicians on 07/31/25 and 08/12/25. Further review of Resident #1's clinical record on 02/02/26 revealed a physician's order dated 01/16/26 instructing the nursing staff to administer the medication, Midodrine, 10 milligrams (mg), orally, three times a day for a systolic blood pressure (SBP) less than 100 (millimeters of mercury). Hold the medication when the SBP is greater than 100. Midodrine is a prescription medication used to treat severe orthostatic hypotension (low blood pressure when standing) by constricting blood vessels, raising blood pressure, and reducing dizziness or fainting. A review of Resident #1's January 2026 medication administration record (MAR) on 02/02/26 revealed the nursing staff administered a 10 mg dose of Midodrine to Resident #1 on the following dates and times: 01/24/26, 6 am, documented blood pressure reading: 102/57.01/28/26. 12 noon, documented blood pressure reading: 108/62.01/29/26, 6 am, documented blood pressure reading: 101/60. These findings were shared with the facility director of nurses (DON) and the Nurse Regional Consultant at the exit conference on 02/04/26. 2) Review of Resident #3's closed clinical record on 02/03/26 revealed that Resident #3 was admitted to the facility on [DATE] with diagnoses that include end stage renal disease on hemodialysis, difficulty walking, osteomyelitis and atrial fibrillation. Resident #3 and had been deemed capable of making all medical decisions by his/her attending physician on 01/16/25. Further review of Resident #3's closed clinical record on 02/03/26 revealed a physician's order dated 03/17/2025 instructing the nursing staff to administer the medication, Amiodarone HCL, 200 milligrams (mg), orally, every 12 hours for atrial fibrillation. Hold the medication if the systolic blood pressure (SBP) is less than 110 or the heart rate is less than 60. A review of Resident #3's August and September 2025 medication administration records (MAR) on 02/03/26 revealed the nursing staff failed to withhold the dose of Amiodarone on the following dates and times: 08/10/25, 8 am dose, documented blood pressure: 106/79.08/12/25, 8 am dose, documented pulse: 58 beats per minute.08/15/25, 8 am dose, documented blood pressure: 101/56. Documented pulse of 53 beats per minute. 09/16/25, 8 pm dose, documented blood pressure: 96/54.09/19/25, 8 pm dose, documented blood pressure: 108/62.09/20/25, 8 pm dose, documented blood pressure: 101/56. Documented pulse of 54 beats per minute.09/21/25, 8 pm dose, documented pulse of 58 beats per minute.09/22/25, 8 am dose, documented blood pressure: 98/57. Documented pulse of 54 beats per minute. Further review of Resident #3's closed clinical record on 02/03/26 revealed a physician's order dated 03/20/2025 instructing the nursing staff to administer the medication, Metoprolol, 25 milligrams (mg), orally, two times a day for hypertension. Hold the medication if the systolic blood pressure (SBP) is less than 100 or the heart rate is less than 60. Further review of Resident #3's August and September 2025 medication administration records (MAR) on 02/03/26 revealed the nursing staff failed to withhold the dose of Metoprolol on the following dates and times: 08/10/25, 8 am dose, documented blood pressure: 106/79.08/12/25, 8 am dose, documented pulse: 58 beats per minute.08/13/25, 8 am dose, documented blood pressure: 81/40. 09/16/25, 8 pm dose, documented blood pressure: 96/54.09/19/25, 8 pm dose, documented blood (continued on next page)

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(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 - Some	pressure: 108/62.09/20/25, 8 pm dose, documented blood pressure: 101/56. Documented pulse of 54 beats per minute.09/21/25, 8 pm dose, documented pulse of 58 beats per minute.09/22/25, 8 am dose, documented blood pressure: 98/57. Documented pulse of 54 beats per minute. These findings were shared with the facility director of nurses (DON) and the Nurse Regional Consultant at the exit conference on 02/04/26.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of a facility reported incident, a closed medical record and staff interview, it was determined that the facility staff failed to obtain psychiatric consultation for Resident #3 after the facility concluded an abuse investigation and determined Resident #3 should be referred to the facility psychiatric services. This is evident for 1 (Resident #3) of 6 residents reviewed during a complaint survey. The findings include: On 09/05/25 the Office of Health Care Quality received a facility reported incident concerning allegations that on Sunday 08/31/25 a nursing staff member (LPN#1) told nursing staff providing care to Resident #3 to not to provide care and that S/he (LPN#1) was also not going to administer any pain medication to Resident #3. Resident #3 was admitted to the facility on [DATE] with diagnoses that include: muscle atrophy, a lack of coordination, difficulty walking, depression, Gout and osteomyelitis of a wound. Resident #3 was deemed capable of making medical decisions by his/her physician on 01/16/25. On 12/06/24 Resident was screened for a history of trauma and determined to have a history of PTSD in the past. A review of Resident #3's nursing care plans revealed a care plan for Depression that was initiated on 12/06/24 that included a focus the Resident #3 is at risk for repression and a positive trauma screen. The goal was that Resident #3 will be free of signs and symptoms of depression. Nursing interventions included: to notify the provider for any risk for harm to self and others, and the nursing staff were to observe for any signs of depression that included hopelessness, anxiety, sadness, verbalizing, tearfulness and repetitive anxious or health-related complaints. Further review of Resident #3's closed medical record revealed a physician's order, dated 03/26/25, instructing the nursing staff to obtain a psychological/psychiatric evaluation upon admission and as needed due to a positive trauma screen. Review of the facility follow-up investigation, the facility staff determined that Resident #3 should be referred to the facility Geri-Psych service provider on 09/12/25. The nursing staff also initiated a care plan on 09/02/25 for a behavior problem identified for Resident #3. The nursing staff identified that Resident #3 has a behavior problem related to yelling out for assistance and not using the call bell. The goal of the behavior care plan is that Resident #3 will have fewer episodes of yelling out for assistance rather than using the call bell. Nursing interventions included: Resident #3 will have my behavior discussed, if I am reasonable. I will be provided with an explanation/reinforcement why behavior is inappropriate and/or unacceptable, I will have my needs anticipated and met, and the nursing staff will monitor my episodes of behavior and attempt to determine underlying cause, and take into consideration location, time of day, persons involved, and situations. The nursing staff will also document my behavior and potential causes. In an interview with the facility Director of Nurses (DON) on 02/24/26 at 2 pm, the DON confirmed that Resident #3 was never assessed by the facility Geri-Psych consultant after the allegation of abuse was brought to the attention of the facility on 08/31/25.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of a closed medical record and all pertinent administrative records, and staff interview, it was determined that the facility failed to have a system in place to ensure clinical records were complete and accurately documented. This was found to be evident for 1 (Resident #3) of 3 residents reviewed during a complaint survey.The findings include:Documentation is an integral part of medication administration. Documentation communicates the timing, dosing, and effect of any medications received by a patient. In the setting of skilled nursing care, residents are often prescribed multiple medications for significant medical conditions. They are also often more vulnerable to medication errors and more prone to changes in conditions that require review and adjustment of their medication regimen. Inaccurate medication documentation has the potential to place residents at significant risk of medication error, provide incomplete or inaccurate information for providers and care givers to evaluate, and represents a failure of basic medication administration principles.Resident #3 was admitted to the facility on [DATE]. Resident #3 was discharged from the facility on 09/25/25. During a review of Resident #3's closed medical record on 02/03/26, the nurse surveyor requested the Director of Nurses to please ask the medical records to bring for review all of Resident #3's closed paper documents and access to Resident #3's electronic medical record. During the review of Resident #3's closed medical record documents, it was discovered that several of the documents were missing from Resident #3's clinical record. The facility staff were unable to produce the documentation/records/sign off MAR sheets/Controlled Medication records from Resident #3's closed medical record: 1) The nursing staff failed to document the number of Oxycontin 10 mg tablets destroyed on Resident #3's-controlled substance administration record on 09/21/25. 2) In an interview with the director of nurses (DON) on 02/04/26 at 2 pm, the DON stated that s/he was unable to locate Resident #3 Oxycodone controlled substance administration record for the dates between 09/05/25 and 09/24/25. 3) A review of Resident #3's Oxycodone 5 mg tablet medication administration record (MAR) for August and September 2025 failed to reveal nursing administration signatures and nursing assessments for doses Resident #3 received on the following days: 08/25/25 at 4 pm09/01/25 at 10:30 pm.09/02/25 at 1:15 pm.09/02/25 at 6:15 pm.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation and staff interviews, it was determined the facility failed to ensure a functioning house wide call bell system. This was evident for all residents residing in the facility's 2 nursing units. The findings include: During an observation of the Cypress Unit on 02/02/26 at 4:08 pm, the nurse surveyor observed resident call bell lights lit above rooms but there was not an audible signal alerting the staff that a residents in rooms were requesting staff assistance. Closer observations of the call bell panel behind the nurse's station/desk, revealed tape covering the enunciator speaker and the enunciator was set to produce a low tone. After several seconds, the enunciator did elicit a sound, but the sound was not audible to this nurse surveyor, the staff or residents walking or sitting on the unit. Further observations of the Federal nursing unit on 02/02/26 revealed the resident call bell light above room [ROOM NUMBER] was light but there was not an audible signal alerting the staff that a resident in room [ROOM NUMBER] was requesting staff assistance. Closer observations of the call bell panel behind the Federal Unit's nurse's station/desk, revealed tape covering the enunciator speaker and the enunciator was nonfunctional. Also, the low or high tone switch to the enunciator was missing. In an interview with the director of maintenance on 02/02/26 at 4:15 pm, stated s/he had not been aware of the call bell system issues prior to the nurse surveyor bringing the concern to his/her attention. In an interview with the facility administrator and director of nurses (DON) on 02/02/25 at 5:05 pm, the facility administrative staff were made aware of the call bell system on the Cypress and Federal nursing units being in disrepair and nonfunctioning.