STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215126	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berlin Nursing and Rehabilitation Center	9715 Healthway Drive Berlin, MD 21811

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's records and interview, it was determined that the facility failed to ensure Residents were free from abuse. This was found to be evident for 2 (Resident #108 & #7) out of 4 Residents reviewed for abuse during the re-certification survey.The findings include: 1) A review of the Facility’s Reported Incident (FRI) #348430 was conducted on 07/17/25 at 11:48 AM. The FRI’s investigation stated that the Resident reported that Geriatric Nursing Assistant (GNA) # 6 pushed him/her by the back of the neck, shoved him/her onto the bed and injured the Resident’s arm. The facility investigated the complaint, suspended GNA #7 on 09/13/24 (the day of the incident) pending the investigation and then terminated her for the allegation of abuse on 09/19/24. During an interview conducted on 07/17/25 at 12:09 PM, the Staff Educator /Infection Control Preventionist stated during the time of the incident she was the acting Director of Nursing (DON) and had conducted the investigation. She advised that she concluded that the GNA abused the Resident and observed a red bruise on the Resident’s arm that was consistent with the Resident’s statement. As a result, GNA #7 was terminated. 2) On 7/22/2025 at 2:30 PM the surveyor conducted a record of the facility’s investigation file for the Facility Reported Incident (FRI) MD#00209510/348428 dated 9/5/2024 that was submitted to the Office of Healthcare Quality (OHCQ). Review of the facility’s investigation file revealed that on 9/5/2024 Geriatric Nursing Assistant (GNA) #24 was accused of hitting Resident #108 on the finger for pointing at the meal tray. According to the facility report, the Resident put his/her right hand in GNA’s face and GNA pushed Resident’s hand out of GNA’s face. Additionally, the facility report indicated that the GNA stated “I did not hit him/her, if I had hit him/her, he/she would know it; no one puts their hand in my face”. Further review of the facility’s investigation file revealed that based on the interviews, the facility verified/substantiated that there was direct contact between GNA #24’s hand and Resident #108’s right hand. The review of the investigation file and the facility reported incident (FRI) form did not reveal that a complaint was filed with the Maryland Board of Nursing (MBON) on GNA #24 for the allegation of physical abuse. The facility suspended GNA #24 immediately for Resident #108’s allegation of physical abuse. Local Law Enforcement was notified of the allegation of physical abuse and Resident #108 was interviewed by an officer from the [NAME] Police Department. The interview revealed that Resident #108 was physically abused by GNA #24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility’s Leadership Policies and Procedures for Abuse, Neglect and Exploitation, or Mistreatment on 7/22/2025 revealed that all alleged violations concerning abuse, neglect, or misappropriation of property are reported verbally immediately to the Facility Abuse Coordinator, the Administrator and to other officials in accordance with state law including the State Survey and Certification Agency (nurse aide registry or licensing authorities). The surveyor conducted a review on 7/23/20254 of GNA #24’s Human Resources personnel file. Review of the personnel file revealed that the facility terminated GNA #24 on 9/11/2024; however, there was no documentation in the personnel file that the facility filed a complaint with the Maryland Board of Nursing (MBON). In an interview with the Licensed Nursing Home Administrator (LNHA) on 7/23/2025 at 9:15 AM the surveyor confirmed that the facility verified/substantiated that physical abuse had occurred to Resident #108 by GNA #24 as concluded on the facility reported incident (FRI) that was submitted to the OHCQ. The LNHA acknowledged the surveyor. During the interview, the surveyor asked the LNHA if the facility filed a complaint on GNA #24 with the Maryland Board of Nursing (MBON) since an allegation of physical abuse was verified and the GNA was terminated by the facility. The LNHA stated that the facility did not file a complaint on GNA #24 with the Maryland Board of Nursing (MBON), but going forward allegations of abuse on licensed staff will be reported to the appropriate licensing board.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **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 Residents received accurate comprehensive assessments. This was found to be evident for 4 (Resident #74, #83,#100 & #11) out of 19 Residents reviewed for accuracy of assessment during the re-certification survey.The findings include: 1) During the interview conducted on 07/15/2025 at 2:19 PM, it was discovered that Resident #74 was hard of hearing and could communicate only using a whiteboard. The Resident stated that he/she could not hear and did not have hearing aids. On 07/18/2025 at 6:16 AM a review of Resident #74’s medical records revealed a diagnosis for unspecified hearing loss, bilateral. The Care Plan is a document that outlines the care and support a Resident needs, often created for individuals receiving healthcare, personal care or other types of support. It’s a personalized roadmap for managing a Resident’s health and well-being, ensuring consistent and coordinated care. Care Plans are not just for nurses; they can be used by various healthcare professionals, caregivers and even the individuals receiving care themselves. Care plans are tailored to the individual’s specific needs, goals and preferences. During a continued review of the resident's medical records, it was discovered that the Resident had a care plan for hearing loss. The care plan stated that Resident #74 will “compensate for hearing loss by utilizing a whiteboard with marker to communicate with staff.” According to the Centers of Medicare and Medicaid Services (CMS) the Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process and provide the foundation upon which a resident's individual care plan is formulated. During an interview conducted on 07/18/23 at 6:49 AM, the Director of Nursing (DON) stated that the Resident hearing was severely impaired and required the use of a white board to communicate with the Resident. This Surveyor questioned why Resident #74’s MDS assessment for hearing assessed the Resident with moderate hearing loss. The DON reviewed the MDS assessment dated [DATE] and confirmed the assessment was not accurate. During an interview conducted on 07/18/25 at 8:42 AM, the DON advised that Resident #74’s MDS hearing assessment was corrected and now showed that the resident’s hearing was highly impaired. 2) The surveyor conducted a record review of Resident #83 electronic medical record on 7/18/2025 at 11:45 AM. Review of the medical record revealed documentation in the progress notes that Resident #83 had a fall (observed sitting on the floor in room on buttock) on 9/29/2024 at 1:03 PM. Further review of the medical record revealed that Resident had a care plan for history of falling related to decreased strength and mobility, but the quarterly MDS assessment dated [DATE] was coded that Resident #83 had no falls. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing (DON) at 12:50 PM on 7/18/2025 the surveyor conveyed to DON that Resident #83 had an unwitnessed fall (found on the floor in room on buttock) on 9/29/2024 at 1:03 PM, but the quarterly MDS assessment dated [DATE] indicated that Resident #83 did not have any falls. The DON acknowledged the surveyor and confirmed that Resident had a fall, and it was not coded accurately on the quarterly MDS assessment. DON stated that she would review with the MDS Coordinator. An indwelling Foley catheter is a flexible tube inserted through the urethra (the tube that carries urine from the urinary bladder to the outside of the body) into the bladder to drain urine. A small balloon inflated with sterile water secures it in place. The indwelling Foley catheter is connected to a drainage bag for urine collection. 3) On 7/21/2025 at 3:15 PM the surveyor conducted a record review of Resident #100’s electronic medical record. The medical record review revealed that Resident #100 had a physician order for an indwelling Foley catheter dated 10/9/2023 and a care plan for an indwelling urinary catheter. Further review of the medical record revealed that Resident #100’s discharge MDS dated [DATE] was coded that Resident had an indwelling catheter, but urinary continence was coded as “occasionally incontinent”. The surveyor conveyed to the Licensed Nursing Home Administrator (LNHA) at 8:10 AM on 7/22/2025 that Resident #100 had a Foley catheter on discharge to the hospital on [DATE], but the discharge MDS assessment dated [DATE] was coded that Resident had an indwelling catheter and coded that Resident was “occasionally incontinent”. The surveyor stated that if the MDS assessment was coded that the Resident had an indwelling catheter then urinary continence should be coded as “Not rated” on the MDS assessment. The LNHA acknowledged the surveyor. In an interview with the Director of Nursing (DON) at 9:00 AM on 7/22/2025 the surveyor conveyed that Resident #100 had an indwelling Foley catheter on discharge11/12/2023 to the hospital, and the discharge MDS assessment dated [DATE] was coded that Resident #100 had an indwelling catheter, but urinary continence was coded as “occasionally incontinent”. Urinary continence should have been coded as “Not rated”. The DON acknowledged and confirmed that Resident #100 had a Foley catheter on discharge and that the discharge MDS dated [DATE] was coded inaccurately for urinary continence and should have been coded as “Not rated”. DON stated that she would review with the MDS Coordinator. No additional information was provided by the facility at the time of exit. 4) Resident #11 was admitted to the facility with diagnoses which included Dementia and Diabetes Mellitus. On 07/16/25 at 8:00 AM the surveyor reviewed Resident #11’s clinical record. The review revealed that the resident fell on [DATE] and complained of pain at the back of the head. Resident #11 was sent to the Hospital emergency room and returned to the facility on [DATE]. Further review of the resident’s clinical record revealed that a quarterly MDS was completed on 09/13/24. The MDS coded the resident under Section J1800 (Falls) as not having any falls since re-entry or the prior assessment. The prior MDS assessment was completed on 06/13/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/25 at 9:20 AM the surveyor interviewed the MDS Coordinator and enquired about the fall which occurred on 07/03/24 not being coded on the quarterly MDS dated [DATE]. The MDS coordinator reviewed the clinical records during the interview, confirmed the surveyor’s findings and stated that the fall should have been coded. “I will speak with my supervisor and make a correction if that is possible” On 07/17/2025 at 9:05 AM the DON was notified of the surveyor's findings and stated that she was already aware of them.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews it was determined that the facility failed to ensure medications were administered as ordered. This was found to be evident for 1 (Resident #102) out of 1 Resident reviewed for a significant medication error during the re-certification survey. This deficient practice resulted in an actual harm cited as past compliance. The findings include: On 07/20/25 at 5:32 PM a review of the Facility Reported Incident (FRI) #348424 revealed a report that advised Resident #102 was mistakenly administered all of Resident #115's morning medications. As a result, the Resident experienced a significant adverse event and was admitted to the local hospital's Intensive Care Unit (ICU) for treatment. A review of Resident #115's Medication Administration Record (MAR) was conducted on 07/20/25 at 5:35 PM. The review of the MAR showed the following morning medications were scheduled to be administered on the day of the incident (8/19/24): Cyanocobalamin (vitamin B-12), Gabapentin capsule 900 mg, Ibuprofen tablet; 800 mg, MiraLAX (polyethylene glycol 3350) 17 gram/dose; MS Contin (morphine) extended release 30 mg, Nubeqa (darolutamide) tablet 300 mg (cancer medication), Senna - S (8.6- 50 mg), and Tamsulosin capsule; 0.4 mg. During an interview conducted on 07/20/25 at 5:49 PM, the Director of Nursing (DON) confirmed that Registered Nurse (RN) 16 administered Resident #115's morning medications to Resident #102. The DON reviewed the MAR with this Surveyor and confirmed that Resident #102 received the following medications: Cyanocobalamin (vitamin B-12), Gabapentin capsule 900 mg, Ibuprofen tablet; 800 mg, MiraLAX (polyethylene glycol 3350) 17 gram/dose; MS Contin (morphine) extended release 30 mg, Nubeqa (darolutamide) tablet 300 mg (cancer medication), Senna - S (8.6- 50 mg), and Tamsulosin capsule; 0.4 mg. A review of Resident #102's progress note dated 08/19/24 from the DON was conducted on 07/20/25 at 6:56PM. The note reported that RN #16 immediately reported her oversight that she administered Resident #102 incorrect medications during the AM (before noon) medication pass. The DON stated, this writer was called to the resident room approximately 0930, immediately after medication was given, resident was noted alert and verbal, and oriented x 2-3.The DON further stated that the Resident was able to follow commands, speech was clear, continued with O2 (oxygen) via nasal cannula for treatment of COPD, bilateral strong hand grasp, pushes, pulls, bilateral strong pedal pushes and pulls. The Physician was notified, gave new orders for neuro checks every 15 minutes, administer Narcan and send to the emergency room for decreased/change in mental status. The Physician also stated that he would be in today to assess the Resident.According to the World Health Organization (WHO) Chronic Obstructive Pulmonary Disease (COPD) is a common lung disease causing restricted airflow and breathing problems. It is sometimes called emphysema or chronic bronchitis. In people with COPD, the lungs can get damaged or clogged with phlegm. According to the National Institute of Drug Abuse Naloxone (Narcan) is a medicine that rapidly reverses an opioid overdose. It is an opioid antagonist. This means that it attaches to opioid receptors and reverses and blocks the effects of other opioids. Naloxone can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose. The DON reported that at approximately 12:45 PM, Resident #102 was noted with decreased mentation, hard to arouse, 911 was called and arrived, Narcan was administered, and the Resident was transported to the local hospital emergency room. A review of Resident #102's hospital discharge summary was conducted on 07/20/25 at 7:04 PM. The discharge summary reported that in the ED (emergency department) the Resident was started on 1 milligram of Narcan infusion and placed on a BiPAP. The Resident was arousable to moderate sternal rub and was able to follow simple commands like moving legs and squeezing hand. The Resident was admitted to the ICU (Intensive Care Unit) for management of unintentional/accidental overdose, acute on chronic hypoxic hypercapnic respiratory failure due to drug overdose as well as hypotension/shock. The report showed that the resident was admitted to the hospital on [DATE] and discharged back to [NAME] Nursing and Rehabilitation on 08/24/24. Biphasic Positive Airway Pressure (BiPAP) is a type of noninvasive ventilation that helps you breathe. Providers can use it to treat you if you're not getting enough oxygen or can't get rid of carbon dioxide. A machine delivers air through a mask on your face.Acute on chronic hypoxic hypercapnic respiratory failure is a serious condition where a patient with an existing chronic respiratory problem experiences a sudden worsening of their breathing, leading to dangerously low oxygen levels (hypoxia) and high carbon dioxide levels (hypercapnia) in the blood. This means the lungs are not effectively exchanging gases, and the body's organs are not getting enough oxygen while accumulating excess carbon dioxide.