STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215132	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer's Head Center	351 Deer's Head Hospital Road Salisbury, MD 21801

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined that the facility failed to ensure that advance directives were discussed with residents and/or responsible representatives. This was found to be evident for 3 (Resident #5, #8 and #7) out of 6 residents reviewed for advance directives during the annual survey.The findings include: 1. An advance directive is a legal document that specifies a person's wishes for end-of-life healthcare. It also specifies who should make healthcare decisions on your behalf if you are unable to do so yourself. During a review of medical records for Resident #5 on [DATE] at 4:05 PM it was revealed that there was no advance directive in the medical records for Resident #5. There was also no documentation of an attempt to obtain any previously created advance directives or that education was provided to the resident or resident's representative about forming advance directives. During a review of medical records for Resident #8 on [DATE] at 4:10 PM it was discovered that there was no advance directive in the medical records for Resident #8. There was also no documentation of an attempt to obtain any previously created advance directives or that education was provided to the resident or resident's representative about forming advance directives. During an interview with the Nursing Home Administrator (NHA) on [DATE] at 9:38 AM she reported that it was standard for the advanced directive information to be included in the admission packet but confirmed there was no documentation of the advanced directives being provided and no documentation of an attempt to obtain any previously created advance directive for Resident #5 or Resident #8. 2. On [DATE] at 7:15 AM, a review of the clinical record for Resident #7 revealed a Maryland Medical Order for Life Sustaining Treatment (MOLST) form, dated [DATE] which indicated the resident was a Full Code per discussion with the resident. The MOLST form is a portable and enduring medical order form covering options for cardiopulmonary resuscitation (CPR) and other life sustaining treatments. Further review revealed that no Advance Directive (AD) nor documentation of a discussion on AD was on Resident# 7's clinical record. In an interview on [DATE] at 7:42 AM the Unit Manager Staff #4 stated that the Social Worker was responsible for AD and that the Social Worker had since resigned. The Unit manager advised the surveyor to speak with the Administrator who is also a Licensed Social Worker and is covering that position temporarily. On [DATE] at 8:10 AM the surveyor interviewed the Administrator who confirmed that she was covering for the Social Worker. The Administrator stated that ADs are discussed upon admission and (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
	215132	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer's Head Center	351 Deer's Head Hospital Road Salisbury, MD 21801

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents/residents' representatives are given paperwork on ADs for completion. The administrator stated that she would review the clinical record of Resident #7 and get back to the surveyor. On [DATE] at 12:17 PM the Administrator in an interview confirmed that there was no AD nor documentation of a discussion on AD on Resident #7's clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215132	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer's Head Center	351 Deer's Head Hospital Road Salisbury, MD 21801

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. Based on facility investigation, medical record review and interviews, it was determined that the facility failed to prevent an incident of resident-to-resident sexual abuse. This was evident for 1 (Resident #20) of 1 resident reviewed for abuse.The findings Include:Brief Interview for Mental Status (BIMS) is a quick, standardized screening tool used primarily in healthcare, especially long-term care facilities, to assess cognitive function. Scores range from 0-15, with higher scores (13-15) indicating intact cognition, while lower scores suggest moderate (8-12) or severe (0-7) impairment.The facility's investigation related to Facility Reported Incident # 340863 was reviewed by the surveyor on 12/09/25 at 6:45 PM. In the investigation, the facility substantiated through a witness, Staff RN # 11, that on 02/21/25 Resident #16 engaged in oral sexual interactions with Resident # 20 who was severely mentally impaired and incapable of giving consent.On 12/09/25 at 7:00 PM a review of the clinical records of Resident #16 and Resident #20 revealed as follows:Resident #16 was admitted to the Dementia Unit in December 2024 with diagnoses including Dementia and a BIMS score of 4 based on the admission MDS with Assessment Reference Date of 12/11/24. By the end of January 2025, the resident had demonstrated numerous inappropriate sexual advances and comments towards staff and other residents.Resident #20 was admitted to the Dementia Unit in November 2021 with diagnoses including Alzheimer's Disease and had a BIMS score of 1 based on an annual MDS with Assessment Reference Date of 02/3/25.On 12/15/2025 at 10:11 AM the surveyor conducted a telephone interview with RN Staff #11 who witnessed the sexual interaction. RN Staff #11stated that on 02/21/25 at around 3:40 PM while making rounds, she observed Resident #16 engaging in oral sexual interactions with Resident #20 on the Sun Porch. RN Staff #11 stated that she immediately separated the residents and called for help. The incident was reported to her supervisor. Both residents were assessed and there were no injuries. Resident #16 was transferred to the ER for evaluation and upon return was moved to a different unit in a private room and placed on 1:1 monitoring after the incident from 2/21/25 to 5/2/25. After the 1:1 observation ended the resident was on 15 minute checks. On 12/10/2025 at 10:08 AM in an interview the Director of Nursing stated that the facility investigated the incident and that the incident was substantiated since there was a witness who observed the interaction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215132	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer's Head Center	351 Deer's Head Hospital Road Salisbury, MD 21801

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on medical record review and interviews, it was determined that the facility failed to provide adequate side effects monitoring for residents on psychotropic medications. This was evident for 2 (Resident #7 and #20) of 5 residents reviewed for unnecessary medications.The findings include:Psychotropic medications are drugs that affect the brain and central nervous system, altering mood, thoughts, perceptions, and behaviors. They are primarily used to treat mental health conditions, such as anxiety, depression, schizophrenia, and bipolar disorder.1) On 12/09/2025 at 6:00 PM a review of Resident #7's medical record revealed that he/she was admitted to the facility in March 2021 with diagnoses which included Major Depressive Disorder, Anxiety Disorder, Borderline Personality Disorder and End Stage Renal Disease.A review of Resident #7's active physician orders for psychotropic medications revealed the following:Abilify 5 mg 1 tablet by mouth every Day Start Date: 01/17/23Hydroxyzine HCL 25 mg I tablet by mouth on Tuesday, Thursday and Saturday at 6:00 AM Start Date:12/12/24Sertraline HCL 100mg I tablet by mouth every Day at 12:00 PM Start Date: 07/23/25Sertraline HCL 50 mg 1 tablet by mouth every day at 12:00 PM Start Date: 04/22/252) On 12/10/25 at 9:42 AM a review of Resident #20's medical record revealed that he/she was admitted to the facility in November 2021 with diagnoses which included Alzheimer's Disease, Epilepsy and Anxiety DisorderA review of Resident #20's active physician orders for psychotropic medications revealed the following:Divalproex Sodium 125 mg Capsule Delayed Release Sprinkle - 2 capsules by mouth two times a day at 6:00 AM and 10:00 PM Start Date: 11/7/24Divalproex Sodium 125 mg Capsule Delayed Release Sprinkle - 3 capsules by mouth one time a day at 2:00 PM Start Date: 11/7/24Risperidone 0.5 mg I tablet by mouth at Bedtime at 9:00 PM Start Date: 05/01/25Risperidone 0.5 mg I tablet by mouth every Day at 8:00 AM Start Date: 05/03/22Further review of Resident #7's and Resident #20's clinical records failed to reveal a process for monitoring side effects of psychotropic drugs, as well as the frequency of and tools used for monitoring.The facility's policy on Psychotropic Medication Management dated 04/2018, last revised 09/2025, Page 3, #12 stated Nursing staff shall monitor for and report side effects and adverse consequences of antipsychotic medications to the LP (Licensed Provider). The policy revealed that drugs in the following categories were considered psychological medications:(i) Antipsychotics,(ii) Antidepressants(iii) Antianxiety(iv) Anticonvulsant(v) Antihistamines(v) HypnoticOn 12/10/2025 at 10:08 AM the surveyor asked the Director of Nursing (DON) whether side effects for psychotropic medications were monitored and what was the process for monitoring. The DON stated that side effects were monitored but not documented daily. Documentation was done by exception when an event occurred, and one would have to look through the nurses' notes to ascertain whether any side effects occurred. The surveyor asked how the nurses knew what side effects they needed to observe. The DON responded that the nurses were familiar with the medications and their side effects and every morning they huddle to discuss the residents. The surveyor requested a copy of the records to verify that side effects were monitored for Resident #7 and Resident #20.On 12/11/2025 at 8:10 AM the DON informed the surveyor that she could not find any documentation on the monitoring of side effects for Resident #7 and Resident #20. She further stated that after the surveyor's intervention, she implemented a system to monitor side effects for all residents on psychotropic drugs, and the nurses were educated on the process. The DON provided the surveyor with documentation to verify that Resident #7 was being monitored for side effects effective 12/10/25 and Resident #20's monitoring started on 12/11/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215132	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer's Head Center	351 Deer's Head Hospital Road Salisbury, MD 21801

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews it was determined that the facility failed to store food in a manner that maintains professional standards of food service safety. This practice had the potential to affect all residents eating food prepared by the facility's kitchen. The findings include:During the initial tour of the Kitchen with the Dietary Manager on 12/08/25 at 9:11 AM there were foods found opened, unlabeled and foods kept past the best by dates. The following foods were identified: In the Walk-in Freezer the following items were found: 1. A clear bag of burger patties that had been opened and removed from the box was undated and unlabeled.2. A box of Oatmeal Raisin Frozen Cookie Dough had been opened with the bag left open to air and was not resealed. The cookie dough was also undated and unlabeled after opening.During an interview with the Dietary Director on 12/08/25 at 9:27 AM she reported items that have been opened should have been covered and labeled with an expiration date. She agreed that the burger patties and cookie dough should have been dated after they were opening. She also reported that the cookie dough should have been resealed after opening.During an observation of the Walk-in Refrigerator on 12/08/25 at 9:31 AM the following items were found past the best buy date:1. Three packages of English Muffins with a Best if used by date of October 16.2. A package of English Muffins with a Best if used by date of November 15.3. Three packages of English Muffins with a Best if used by date of of November 16.4. Four packages of English Muffins with a Best if used by date of November 23.5. Two loaves of Texas Toast Bread with a Best if used by date of November 03.6. Four loaves of Whole Wheat Bread with a Best if used by date of December 03.7. Nine loaves of Enriched [NAME] with a Best if used by date of December 03.8. A Bag of 12 Individual Hamburger rolls with a Best if used by date of October 30.9. Three Bags of 12 Individual Hamburger rolls with a Best if used by date of November 28.10. Three loaves of Whole Wheat Bread labeled with a Best if used by date of November 26.11. Nine loaves of Enriched [NAME] with a Best if used by date of December 03.12. Four loaves of Classic [NAME] Bread with a Best if used by date of November 24.13. Three bags of Deli Split top rolls with a Best if used by date of December 5.14. Two loaves of Rye bread with a Best if used by date of November 07.15. A bag of Italian Hoagie Rolls with a Best if used by date of November 02.16. A bag of Italian Hoagie Rolls with a Best if used by date of November 27.17. A loaf of Cinnamon Swirl Bread with Raisins with a Best if used by date of November 22. During an observation of the Kitchen's Toasting Station on 12/08/25 at 9:33 AM it was discovered to have the following items past the Best if used by date:1. A package of English Muffins with a Best if used by date of October 16.2. An opened loaf of Cinnamon Swirl Bread with a Best if used by date of October 27.3. An opened loaf of Cinnamon Swirl Bread with a Best if used by date of November 15.4. An opened loaf of Whole Rye Bread with a Best if used by date of November 075. An opened loaf of Whole Wheat Bread with a Best if used by date of November 26.During an interview with the Dietary Director on 12/08/25 at 9:52 AM she reported the bread at the toaster station should been thrown away and that staff should have checked the dates before using the loaves of bread. She reported the outdated bread in the refrigerator should not be in there and advised she doesn't know why there is so much outdated bread. During a review of the facility's Dietary-Sanitation: Dating Potentially Hazardous Food policy on 12/11/25 at 12: 21 PM it was discovered all potentially hazardous, ready to eat food will be labeled and dated to ensure appropriate rotation of food and to prevent or reduce food borne illness. It also sated, All perishable products are covered or closed in refrigeration, frozen and dry storage areas.During a review of the facility's Food Storage Chart for Retaining Food Quality on 12/11/25 at 12:26 PM it was revealed that bread expiration is the Best by, Sell by date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215132	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer's Head Center	351 Deer's Head Hospital Road Salisbury, MD 21801

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 observations and staff interviews, it was determined that the facility failed to 1) maintain appropriate infection control practices for a resident with an indwelling urinary catheter and 2) store clean laundry in a manner that minimized the potential for the spread of infection. This was evident for 1 (Resident #6) out of 1 resident reviewed for urinary catheters and 1 random observation of the laundry room during the annual survey.The findings include:1. An indwelling urinary catheter is a tube that remains in the bladder to drain urine into a collection bag. On 12/08/25 at 12:37 PM, the surveyor observed Resident #6 lying in bed with his/her urinary drainage bag hanging from the side of the bed and touching the floor. On 12/08/25 at 12:40 PM, an interview with Charge Registered Nurse (RN) #1 confirmed that she was the assigned nurse for Resident #6 and that the urinary drainage bag was touching the floor. Charge RN #1 stated that she had just lowered Resident #6's bed and acknowledged that the urinary drainage bag should not be touching the floor. On 12/09/25 at 9:42 AM, an interview with the Director of Nursing (DON) confirmed that the expectation is for urinary drainage bags to remain off the floor. At the time of the exit conference, the findings were reviewed with the Director of Nursing (DON) and the Nursing Home Administrator, who acknowledged the deficiency. 2. On 12/09/25 at 11:00 AM the surveyor did a walkthrough of the laundry room with Laundry Aide #6. The surveyor observed a large blue bin in the clean area of the laundry room with its contents overflowing and exposed. Inside the bin were folded green hospital gowns, heel protectors and pillows. None of the items were covered. Laundry Aide #6 who accompanied the surveyor stated that the contents of the bin were clean and acknowledged that they should have protective coverings as an infection control measure. On 12/09/25 at 11:18 AM in an interview, the concerns regarding the laundry room were brought to the attention of Environmental Services Supervisor Staff #10 who stated that he would address the issue. On 12/09/25 at 12:17 PM the Administrator was made aware of the observations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215132	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer's Head Center	351 Deer's Head Hospital Road Salisbury, MD 21801

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews, it was determined that the facility failed to keep a sanitary environment in the laundry. This was evident during 1 random observation of the laundry room during the annual survey.The findings include:On 12/09/25 at 11:00 AM the surveyor did a walkthrough of the laundry room with Laundry Aide #6. The surveyor observed a large amount of white lint heaped on the floor next to a white dryer. A broom was resting on top of the lint heap. Laundry Aide #6 stated that he had cleaned the dryer at 7:00 AM and left the lint on the floor I should have put it in the trash, but I did not.Further observation of the laundry room revealed three small washing machines with spillage of a blue substance on their covers. Inside two of the washing machines were visibly dirty bleach dispensers. Thick blackened material was observed around the edges of the bleach dispensers.On 12/09/25 at 11:18 AM in an interview, the concerns regarding the laundry room were brought to the attention of Environmental Services Supervisor Staff #10 who stated that he would address the issues.On 12/09/25 at 12:17 PM the Administrator was made aware of the observations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215132	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer's Head Center	351 Deer's Head Hospital Road Salisbury, MD 21801

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation and interview, it was determined that the facility failed to post all required staffing information on a daily basis. This was evident in 2 of 2 units observed during the recertification survey.The findings include: On 12/10/25 at 11:52 AM, during an observation in the Magnolia Manor (MM) unit, the whiteboard that contained the staffing schedule did not indicate the facility name or the resident census.On 12/11/25 at 12:40 PM, another observation was conducted in the Whispering [NAME] (WW) unit, the whiteboard also did not indicate the facility name or the resident census.On 12/15/25 at 1:07PM, during the observation conducted in the MM unit, the posted nurse staffing information only included the date, shift, and the staffing schedule with the ratio. In an interview with Registered Nurse (RN #3), he/she confirmed completing the board at the beginning of the shift, however, failed to indicate the name of the facility and specify the resident census. At 1:12 PM, in an observation in WW unit, the posted nurse staffing schedule had a similar concern. RN #1 confirmed the resident census was not specified and stated that the total number of residents was usually written beside their names. RN #1 posted census 14, MLOA-2 (medical leave) after surveyor intervention.On 12/15/2025 at 2:20 PM, in an interview with the Director of Nursing (DON), she stated that she expected to see the date, the assignment and the staff-to-patient ratio written on the board. She was notified of this concern and acknowledged the finding.