STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hartley Nursing and Rehab	1006 Market Street Pocomoke City, MD 21851

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to develop and implement comprehensive care plans for the use of 1) oxygen (O2) therapy and 2) cardiac medications. This was evident for 4 (Residents #45, #62, #53 and #2) of 23 residents reviewed for care planning during the recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each Resident. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. The care plan consists of focus, goal and interventions. 1a. On 1/14/2026 at 10:30 AM, during the initial tour of the facility, Resident #45's O2 concentrator was found turned off with tubing on the floor, under the bed. On 1/14/2026 at 10:39 AM, Unit Manager (UM #2) was informed of the findings and confirmed that Resident #45 was currently on O2 therapy. On 10/16/2025 at 10:45 AM, during an interview with the Director of Nursing (DON), she stated that resident's care plan was initiated by the UM and updated by the DON as needed.On 1/20/2026 at 8:39 PM, a review of Resident #45's Physician orders indicated an order 02 at 2L (liters) /minute via nasal cannula (NC) continuous related to (r/t) low saturations (sats) every shift The following progress notes confirmed that Resident #45 was on O2 therapy:1/12/2026 05:46 Orders- Administration Note Text: 02 at 2L/min via NC continuous r/t low satsevery shift1/15/2026 00:19 Orders- Administration Note Text: 02 at 2L/min via NC continuous r/t low satsevery shift1/16/2026 02:25 Orders- Administration Note Text: 02 at 2L/min via NC continuous r/t low satsevery shift1/19/2026 23:28 Orders- Administration Note Text: 02 at 2L/min via NC continuous r/t low satsevery shiftThe medical record did not indicate any evidence that an O2 therapy care plan was in place.On 1/21/2026 at 10:05 AM, the surveyor received a copy of Resident #45's O2 care plan which was initiated on 1/21/26 after surveyor intervention.1b. On 1/14/2026 at 9:58, Resident #62 was observed using O2 via NC connected to a cylinder tank. UM #2 stated that probably the facility ran out of O2 concentrators. On 10/16/2025 at 10:45 AM, the DON was informed that Resident #62 had no O2 care plan.On 1/20/2026 at 9:45 PM, a review of Resident #62's order confirmed the use of O2 via NC at 3L/min for shortness of breath (SOB)/low pox (oxygen saturation) every shift. However, a care plan for O2 use was created on 1/16/26 after surveyor intervention.1c. On 1/14/2026 at 9:53 AM, Resident #53 was observed in bed receiving O2 therapy via NC.On 1/15/2026 at 12:37 PM, a review of Resident #62's physician orders did not indicate any evidence that an O2 order was placed, nor a care plan was initiated and implemented.A change in condition noted dated 1/12/2026 at 11:28 PM confirmed that Resident #53 was on O2 at 3L/m via NC. On 1/21/2026 at 10:15 AM, a review of the facility's oxygen administration policy which was reviewed and revised on 4/18/25 required the following, 1. Oxygen is administered under orders of a physician, except in the case of emergency. 4. The Resident's Care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders.On 1/21/2026 at 11:25 AM, the DON and Assistant Director of Nursing (ADON) were informed of the concerns and acknowledged the findings. 2. On 1/20/2026 at 8:00 PM, a review of Resident #2's medical record indicated an admission date of 11/18/25 and a discharge to the hospital on [DATE]. A review of the change in condition report dated 12/29/25 indicated the following: a. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Abnormal vital signs- elevated pulse of 123, respiration of 36 and low blood pressure of 60/39b. Change in mental status- difficult to arouse, general weaknessThese findings were confirmed by a Physician's discharged note dated 12/30/25 at 7:27 PM. Further review of Resident #2's order summary indicated that he/she was prescribed the following medications: - Amiodarone (hydrochloride) HCl Oral Tablet 200 MG for chronic atrial fibrillation (irregular heartbeat which may lead to fatigue, shortness of breath and increases stroke risk.- Amlodipine Besylate Oral Tablet 10 MG (Amlodipine -Besylate) for hypertension (a blood pressure reading of 130/80 or higher)- Apixaban Oral Tablet 5 MG for chronic atrial fibrillation- Aspirin Oral Tablet Chewable 81 MG for cerebral infarction (is a type of stroke where a blockage such as blood clot, cuts off blood flow to part of the brain)- Atorvastatin Calcium Tablet 80 MG hyperlipidemia (high levels of bad cholesterol in the blood- Furosemide Oral Tablet 40 MG for heart failure (a condition when both left and right side of the heart are too weak to function)- Metoprolol Succinate extended release (ER) 50 mg Tablet for hypertension- Eliquis 5 MG Tablet for cerebral infarction- Sacubitril-Valsartan Oral Tablet 49-51 MG for heart failureHowever, the medical record did not show the care plan addressing these medications were initiated. On 1/21/2026 at 11:43 AM, the DON confirmed that facility failed to initiate the required care plan. On 1/23/2026 at 8:45 AM, the Nursing Home Administrator (NHA) was notified of these concerns.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, it was determined that the facility failed to provide necessary respiratory care services by failing to label oxygen administration equipment. This was evident for 4 (Resident #57, #53, #62 and #45) of 4 residents reviewed for respiratory care during the recertification survey. The findings include: Oxygen (O2) therapy is a treatment that provides a person with extra O2 to breathe in. It is also called supplemental O2. A nasal cannula is a thin, flexible tube that delivers O2 through the nose. A humidifier in O2 therapy is a device that adds moisture to dry, concentrated O2 to prevent drying and irritation of a patient's nasal passages, throat, and lungs. These humidifiers typically consist of a bottle filled with water that attaches to an O2 concentrator. On 1/14/2026 at 9:47 AM, during the initial tour of the facility, Resident #57 was observed in bed receiving O2 therapy via nasal cannula (NC), both the tubing and the humidifier bottle were unlabeled. On 1/14/2026 at 9:53 AM, Resident #53 was also observed using unlabeled tubing and an unlabeled humidifier. On 1/14/2026 at 9:58, Resident #62 was using unlabeled tubing that was connected to a cylinder tank.On 1/14/2026 at 10:30 AM, Resident #45's O2 concentrator was found turned off. Neither the tubing nor the humidifier bottle were labeled with the date of use nor the scheduled replacement date. On 1/14/2026 at 10:39 AM, Unit Manager (UM #2) was informed of the findings and verified these observations. He/she stated that O2 tubing were changed every Tuesday night, and the humidifier as needed. She added that it was expected that O2 tubing and humidifier bottles were labeled accordingly. On 10/16/2025 at 10:45 AM, the Director of Nursing (DON) was informed of these concerns and acknowledged the findings. On 1/23/2026 at 8:45 AM, the Nursing Home Administrator (NHA) was notified of these concerns.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on a review of staffing sheets and interview, it was determined that the facility failed to ensure a registered nurse (RN) was on duty of at least 8 consecutive hours, 7 days a week. This was evident for 2 of 23 days reviewed during the recertification survey and has the potential to affect all residents. The findings include: On 1/20/2026 at 10:14 AM, a review of the staffing sheets revealed that no RN worked during the 7-3 and 3- 11 shifts on Sunday, January 4, 2026, or the 3-11 shift on Saturday, January 10, 2026. On 1/21/2026 at 12:22 PM, in an interview with the Director of Nursing (DON), she confirmed that although she was the on-call RN on January 4, she was unable to fulfill her duties due to personal reasons. On 1/21/2026 at 12:34 PM, the Assistant Director of Nursing (ADON) confirmed she was the on- call RN on January 10 but did not report to the facility. Both the DON and the ADON have been notified of these concerns.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, it was determined that the facility failed to store and prepare food in a manner that maintained professional standards of food service safety. This practice had the potential to affect all residents eating food prepared in the facility's kitchen. The findings include:During the initial tour of the kitchen conducted on 01/14/2026 at 9:40 AM, the Surveyor and Food Service Director observed multiple food items stored in the dry storage area that were opened and undated or had illegible labeling. The food items were identified as follows: 2 packs of ziti noodles, opened and undated; 2 packs of elbow noodles, opened and undated; 1 pack of egg noodles, opened with illegible labeling; 2 packs of egg noodles, opened and undated; 1 pack of spaghetti noodles, opened and undated; 1 box of egg noodles, opened with no expiration or open date; 1 bag of toasted oats cereal, opened and undated; and 1 bag of crisp rice cereal, opened and undated.During a continued tour of the kitchen, the Surveyor and Food Service Director observed food items stored in the walk-in refrigerator that were opened and undated. The food items were identified as 1 box of ground beef, opened and undated; 1 box of natural smoked bacon, open to air and undated; 1 bag of red potatoes, opened and undated; and 3 packs of French toast, opened and undated.In an interview conducted on 01/14/2026 at 9:55 AM, the Food Service Director stated that the facility's expectation was for food items to be securely closed once opened and labeled with an open date and expiration date to ensure safe food storage.During a continued tour of the kitchen, the Surveyor and Food Service Director observed food items stored in the walk-in freezer that were opened, exposed to air, and undated. The food items were identified as 1 box of corn, open to air and undated; 1 box of cultivated blueberries, open to air and undated; 1 box of pizza dough, open to air and undated; 1 bag of sugar cookie dough, opened and undated; 1 box of philly beef sandwich slices, opened and undated; 1 box of breakfast turkey sausage patties, opened and undated; 1 box of bulk beef hamburger patties, opened and undated; and 1 pack of hot dogs, opened and undated.During continued observations of the dishwashing area on 01/14/2026, the Surveyor and Food Service Director observed the facility's high-temperature dishwasher in operation. The wash cycle temperature reached approximately 140 degrees Fahrenheit (F) as indicated on the dishwasher manifold gauge, which was below the required wash temperature of 150 degrees F. The rinse cycle temperature reached approximately 186 degrees F; however, the temperature gauge remained fixed and did not reset to zero during or after the cycle.In an interview conducted on 01/14/2026 at 10:43 AM, the Food Service Director stated that the dishwasher was expected to reach required wash (150 degrees F) and rinse (180 degrees F) temperatures.During a follow-up kitchen tour conducted on 01/21/2026 at 11:08 AM, the Surveyor and Food Service Director again observed the facility's high-temperature dishwasher in operation. The wash cycle temperature reached approximately 144 degrees F as indicated on the dishwasher manifold gauge, which was below the required wash temperature of 150 degrees F. The rinse cycle temperature reached approximately 190 degrees F; however, the temperature gauge again remained fixed and did not reset to zero during or after the cycle.On 01/23/2026, the Administrator was made aware of the above findings.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews, it was determined that the facility failed to notify the Physician and Resident Representative (RP) of the residents' change in condition. This was evident for 2 (Resident #5 and Resident #57) of 4 residents reviewed for hospitalizations during the recertification survey. The findings include: 1. On 1/22/26, review of Resident #5's clinical record revealed that the resident was transferred to the hospital on 1/6/26 following a change in condition and returned to the facility on 1/14/26. There was no documentation in the clinical record to verify that the physician was notified of Resident #5's change in condition on 1/6/26. Further review of Resident #5's clinical record revealed a late entry nursing progress note dated 1/7/26 that was entered into PointClickCare (PCC), the facility's electronic medical record system, on 1/15/26. The progress note revealed that Resident #5 had a change in mental status and abdominal pain and was sent to the emergency room for evaluation and treatment; however, the note did not include documentation to show that the physician was notified of Resident #5's change in condition. On 1/22/26 at 10:30 AM, an interview with the Assistant Director of Nursing (ADON) revealed that when a resident has a change in condition, nursing staff is expected to notify the physician. The ADON stated that physician notification is documented by nursing staff in a Change In Condition (CIC) note in PCC. At 10:34 AM, the surveyor requested documentation to verify physician notification for Resident #5's change in condition, which resulted in hospital transfer on 1/6/26. In a follow-up interview on 1/22/26 at 11:05 AM, the ADON confirmed that no CIC note was completed for Resident #5 and stated that only a late entry progress note dated 1/7/26 was in PCC. At the time of the exit conference, no documentation was provided to verify that the physician was notified of Resident #5's change in condition, which resulted in a hospital transfer on 1/6/26. 2. Pulse oximetry is a noninvasive, painless method to measure the oxygen saturation level in the blood (SpO2) and pulse rate using a small device (pulse oximeter) usually placed on the finger. A normal healthy reading is generally 95-100 %. Readings below 92 % may indicate low oxygen, and levels at 88% or lower require immediate medical attention. On 1/22/26 at 9:13 AM, a review of Resident #57's change in condition report dated 12/7/25 at 5:29 PM indicated the following: Situation: Shortness of breath Pulse Oximetry: SpO2 88% (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Method: O2 via nasal cannula Primary Care Provider Feedback: A. Recommendations: send to emergency room for evaluation and treatment. Despite these clinical developments, the report contained no evidence that the RP was notified of the change in condition. On 1/22/26 at 12:09 PM, the Director of Nursing (DON) provided a copy of the report and confirmed that the RP had not been notified and acknowledged this concern.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations and interviews, it was determined that the facility failed to provide clean, comfortable and homelike environment for residents. This was evident for 2 (Resident #1 and Resident #48) during an initial tour of the facility. 1.On 1/14/26 at 10:25 AM during rounds the surveyor observed Resident #1 lying in bed with a wheelchair at the bedside. The resident stated that his/her bathroom door was locked for weeks and he/she could only use the bathroom when a staff member was present. The surveyor tried to open the bathroom door, but it was locked. Also, on the floor next to the wall facing the resident were several items. The items included a pair of wheelchair foot-rests, and a cardboard box containing personal items such as shoes and clothing.The surveyor informed Staff LPN #7 of the concerns and Staff LPN #7 accompanied the surveyor to Resident #1's room and confirmed the findings. Staff LPN #7 stated that the bathroom door was locked to protect the resident from falls. She also stated that the items on the floor should not be there and that she would have them removed. The surveyor asked to speak to the Director of Nursing (DON). Later at 11:50 AM the DON arrived in the resident's room. The DON tried to open the resident's bathroom door and confirmed that it was locked. The DON stated that the door was locked because Resident #1 was a fall risk and he/she would try to use the bathroom without calling for help. Further, Resident #1 was usually incontinent and was dependent on staff for toileting.On 01/15/26 at 7:45 AM a review of the resident's Care Plan for Falls, failed to reveal the locked bathroom was an intervention to keep Resident #1 safe. On 1/16/26 at 8:39 AM in an interview the DON was notified of the surveyor's concerns regarding the facility's failure to provide a comfortable homelike environment as evidenced by personal items on the floor and the resident not having access to his/her bathroom. The DON stated that she would address the findings. 2. On 01/14/26 at 10:54 AM the surveyor observed Resident #48 sitting at the side of his/her bed. On the floor under the window there were a box of crackers, a case of 8oz bottled drinking water, 2 bottles of shampoo and personal items in 3 gift bags. In an interview Staff LPN #7 who was with the surveyor confirmed the findings and stated that the items should not be on the floor and they would be removed.On 1/14/26 at 11:58 AM the DON accompanied the surveyor to Resident #48's room and confirmed the items on the floor. During an interview, the DON stated that she would address the concerns as food items were not allowed on the floor and the staff was expected to ensure that food was stored in containers with lids. She also stated that the other items would be removed from the floor.On 01/23/2026 at 8:57 AM during follow-up rounds the surveyor observed the case of bottled water, shampoo and other personal items still on the floor of Resident #48's room. The only item which was removed was the box of crackers. At 9:53 AM the surveyor again brought the concerns to DON's attention. I told the GNA (Geriatric Nursing Assistant) to remove them, I will remove them right now. The surveyor observed the DON removing the items from the floor.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interviews, it was determined the facility failed to review and revise the interdisciplinary care plans as changes in residents' treatment occurred. This was evident for 2 (Resident #3 and Resident #7) of 23 residents reviewed for care planning. The findings include:1. On 01/21/26 at 12:27 PM a review of Resident's #3 medical record revealed that on 12/23/25 the resident acquired an Arterial Ulcer to the Right Heel. The current treatment order for the ulcer is as follows: Cleanse Right Heel Arterial Ulcer with wound cleanser/normal saline. Apply calcium alginate, Medi honey to base of wound and secure with ABD and rolled gauze daily every evening shift - Start Date: 01/15/26Further review of the resident's medical record revealed that on 11/20/25 upon admission, a care plan was initiated which stated that the Resident #3 has potential for pressure ulcer development.The medical record failed to reveal that Resident #3's care plan was reviewed and revised to include the presence of an actual Arterial Ulcer. Further, there were no interventions in place to address the condition. On 01/22/26 at 10:25 AM during an interview, Unit Manager LPN #2 stated that residents' care plans were reviewed and revised in keeping with their condition. The Unit Manager LPN #2 reviewed the medical records and acknowledged that the care plan was not revised to include Resident #3's Arterial Ulcer. On 01/22/26 at 10:33 AM in an interview the Director of Nursing (DON) was informed of the concerns and acknowledged the findings. 2. A review of Resident #7's medical record revealed that the resident was admitted to the facility in April 2023 with diagnoses which included Atrial Fibrillation and Hypertension.Further review indicated that the resident was receiving anticoagulant, Eliquis 5mg by mouth twice a day for Atrial Fibrillation. Order Start Date: 11/12/25.The medical record failed to reveal that a Care Plan with interventions for anticoagulant therapy was implemented for Resident #7.On 01/22/26 at 10:10 AM during an interview Unit Manager LPN #2 stated that it was the practice for residents on anticoagulant therapy to have Care Plans with interventions for the condition. Unit Manager LPN #2 reviewed the clinical record with the surveyor and confirmed that a Care Plan was not initiated. On 01/22/26 at 10:30 AM in an interview the DON was informed of the findings, and she also reviewed the clinical record and confirmed the findings. The DON stated that a Care Plan should have been in place but it was missed.On 01/22/2026 at 10:57 AM the surveyor received an updated Care Plan from Unit Manager LPN #2 with interventions for Anticoagulant therapy for Resident #7.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, record review and interview, it was determined that the facility failed to ensure that resident received treatment for a rash present since admission. This was evident for 1 (Resident #9) of 23 residents reviewed during the recertification survey. The findings include: Nystatin powder is a prescription medicine designed to treat skin infections caused by fungus or yeast. On 1/15/2026 at 8:59 AM, Resident #9 was observed with redness on the chest and confirmed the condition existed since admission. On 1/22/2026 at 6:18 PM, a review of Resident #9's medical record indicated an admission of 12/3/25 and a BIMS (Brief Interview for Mental Status) score of 15 which indicated intact cognitive function. A review of the skin treatment order written on 12/3/25 indicated: Nystatin External Powder 100000 UNIT/GM (Nystatin (Topical)) Apply to abdominal folds topically four times a day for yeast rash. However, no treatment was ordered for the chest/breast area.A review of the progress notes revealed the following:12/4/2025 00:45 Skilled Evaluation #006: New skin Issue. Location: Left breast, Issue type: Rash. Wound was present on admission.#007: New skin Issue. Location: Right breast, Issue type: Rash. Wound was present on admission 1/22/2026 18:09 Skilled Evaluation #004: Skin issue has not been evaluated. Location: Left breast. Issue type: Rash. Wound was present on admission.#005: Skin issue has not been evaluated. Location: Right breast. Issue type: Rash. Wound was present on admission on [DATE] at 8:39 AM, during an interview with the Assistant Director of Nursing/ Infection Preventionist (ADON/IP) Nurse, she stated that she was unsure if the Physician had been notified and committed to finding out why the issue remained unaddressed. On 1/23/2026 at 9:49 AM, a review of the skin treatment order revealed that a new order was written after surveyor intervention. Nystop External Powder 100000 UNIT/GM (Nystatin (Topical)) Apply to bilateral breast topically every day and evening shift for rash for 15 Days. On 1/23/2026 at 10:07 AM, in an interview with Registered Nurse (RN #6), he/she confirmed that on admission, the admitting nurse documents the skin issues in the medical record and the wound book for the wound nurse to review. On 1/23/2026 at 10:20 AM, the ADON/IP Nurse confirmed that the initial admission order failed to address the correct sites and stated that a corrected order has since been implemented.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, it was determined that the facility failed to ensure that nursing staff received competency evaluations upon hire and annually thereafter. This was evident for 3 (Geriatric Nurse Assistant GNA #8, Registered Nurse RN #9 and Licensed Practical Nurse LPN #12) of 5 randomly selected nursing staff reviewed for staff competency during the recertification survey.The findings include: Nursing competence is defined by the American Nurses Association as an expected level of performance that integrates knowledge, skills, abilities, and judgment. On 1/16/2026 at 9:11 AM, during an interview with Staff #1, he/she stated that the Assistant Director of Nursing or Infection Preventionist (ADON/IP) Nurse serves as the facility's official Staff Educator. He/she added that staff training upon hire and annually was a collective effort involving the Director of Nursing (DON), the Nursing Home Administrator (NHA), and the ADON/IP Nurse/Staff Educator. On 1/21/2026 at 8:27 AM, a review of the nursing employee records revealed the following: 1. GNA #8 was hired 2/23/24, no competency evaluation was found.2. RN #9 was hired on 10/10/23, no competency evaluation was found.3. LPN #12 was hired on 1/29/24, no competency evaluation was found. On 1/21/2026 at 9:48 AM, in an interview with GNA #16, he/she confirmed that he/she had not received any competency training since his/her hire date. On 1/21/2026 at 11:19 AM, the DON and the ADON/IP Nurse/Staff Educator, explained that competency training involved evaluating the nursing staff members through return demonstrations of skills listed on a competency checklist. The DON was notified that only 2 competency checklists were found among the reviewed files, and several staff members had no checklist at all. The ADON/IP Nurse/ Staff educator stated, That's all that we have, and confirmed that all the relevant documents were stored in employee folders and were not located elsewhere in the facility. They were notified of the concerns and acknowledged these findings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on medical record review and interviews, it was determined that the facility failed to ensure that a recommendation by the consulting pharmacist was followed and documented on the resident's record. This was evident for 1 (Resident #11) of 5 residents reviewed for pharmacy recommendations. The findings include:On 1/20/26 at 11:45 AM a review of Resident #11's medical record revealed that the resident was receiving the medication Polyethylene Glycol Powder 17 gram by mouth daily for Constipation. Start Date: 09/22/25.Further review of the medical record revealed a recommendation by the facility's consulting pharmacist dated 8/01/25 with the following information Polyethylene glycol powder. Please add to mix 4 to 8 ounces of water or non-carbonated beverage of choice. The recommendation was reviewed and signed by the resident's physician on 8/11/25 with a note AGREE: Please write orders.A review of Resident #11's Medication Administration Record (MAR) revealed that from 09/22/25 to 01/20/25, the resident received the medication daily. The MAR did not contain documentation of the pharmacist's recommendation.In an interview on 01/20/26 at 1:19 PM, Unit Manager LPN Staff #3 stated that Resident #11 was hospitalized in September 2025 and upon return, the medication instructions were not updated on the MAR. Unit Manager LPN Staff #3 stated that she would update the record.In an interview on 01/20/26 at 1:44 PM the Director of Nursing was informed of the surveyor's concerns and acknowledged the findings.After the surveyor's intervention, Resident #11's medical record was updated on 01/21/26 to include the pharmacist's recommendation for Polyethylene Glycol Powder.

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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 observation, interview and record review, it was determined that the facility failed to use appropriate infection control practices such as 1) improper use and care of oxygen administration equipment, 2) improper storage of clean linens, and 3) inadequate infection surveillance. This was evident for 1) 1 (Resident #45) of 1 resident, 2) 1 of 1 laundry observation, and 3) 9 of 9 months of infection surveillance reviewed during the recertification survey.The findings include: 1) Oxygen (O2) therapy is a treatment that provides a person with extra O2 to breathe in. It is also called supplemental O2. A nasal cannula is a thin, flexible tube that delivers O2 through the nose. On 1/14/2026 at 10:30 AM, during the initial rounds of the facility, Resident #45's O2 concentrator was found turned off with the nasal cannula resting on the floor under the bed. On 1/14/2026 at 10:39 AM, Unit Manager (UM #2) was informed of the finding and verified this observation. He/she confirmed that nasal cannulas not in use should be stored in a clean plastic bag. On 10/16/2025 at 10:45 AM, the Director of Nursing (DON) was notified of this concern and acknowledged the finding. 2) On 1/20/2026 at 7:10 PM, a review of the infection tracking logs from May 2025 to January 2026 revealed significant inconsistencies. Logs lacked critical data, including unit and room numbers, onset dates, specific organisms, symptoms, and whether infections were hospital or community acquired. Furthermore, logs for May and September lacked the signatures of the Infection Preventionist (IP) Nurse and the dates of report to the Quality Assurance and Assurance (QAA) Committee. (QAA is Quality Assessment and Assurance is a mandated committee that reviews the facility data, identifies quality deficiencies and develops corrective action plans.) On 1/21/2026 at 10:39 AM, the Assistant Director of Nursing/ Infection Preventionist Nurse (ADON/IP Nurse) confirmed that daily infection surveillance for January was not available as the log was still being created. On 1/23/2026 at 8:45 AM, the Nursing Home Administrator (NHA) was notified of these systemic tracking failures and acknowledged the findings. 3) On 1/16/2026 at 8:46 AM, the Maintenance Director/ Environmental Services and Laundry Manager described the required infection control procedure for handling soiled linens, noting that staff must wear an apron or gown, mask, gloves, and a face shield. However, on 1/16/2026 at 8:54 AM, during a tour in the laundry area, several personal items including a can of soda, a box of facial tissue and a bottle of lotion were found on top of a table used for clean, folded linens. A cellphone was also observed on top of the clean folding table. The Maintenance Director was notified and acknowledged these concerns. On 1/16/2026 at 9:07 AM, the Nursing Home Administrator was also informed of these findings. On 1/23/2026 at 10:20 AM, Maintenance Director confirmed that he has completed education for the relevant staff regarding these laundry and infection control issues.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and interview, it was determined that the facility failed to collect all the information required for monitoring antibiotic stewardship. This was evident for 9 of 9 months of antibiotic logs reviewed during the recertification survey. This deficient practice has the potential to affect all residents in the facility.The findings include:Antibiotic stewardship requires a facility to develop and implement policies, procedures and/or protocols to ensure residents who need antibiotics are treated appropriately. This is to reduce the risk of residents having adverse reactions to antibiotics, receiving them unnecessarily and/or developing antibiotic-resistant organisms. A facility-wide process must be in place to monitor the use of antibiotics so the results/feedback can be reported to nursing staff and prescribing clinicians.On 1/20/2026 at 7:10 PM, a review of the antibiotic surveillance logs from May 2025 to January 2026 revealed significant inconsistencies. Logs lacked critical data, including onset dates, room numbers, antibiotic order, diagnosis, ordering practitioner, and documentation supporting necessity. Furthermore, log for September lacked the signature of the Infection Preventionist (IP) Nurse and the dates of report to the Quality Assurance and Assurance (QAA) Committee. (QAA is Quality Assessment and Assurance is a mandated committee that reviews the facility data, identifies quality deficiencies and develops corrective action plans.) On 1/21/2026 at 10:39 AM, the Assistant Director of Nursing/Infection preventionist Nurse (ADON/IP Nurse) confirmed that daily antibiotic surveillance for January was not available as the log was still being created. On 1/23/2026 at 8:45 AM, the Nursing Home Administrator (NHA) was notified of these systemic tracking failures and acknowledged the findings.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to screen, offer and educate the residents or the Responsible Parties (RP) of risks and benefits of pneumococcal vaccines and flu vaccines. This was evident for 4 (Resident #62, #57, #45 and #9) of 5 residents randomly reviewed for immunizations. The findings include: According to Centers for Disease Control (CDC), flu vaccine is an annual injection (or nasal spray) recommended for everyone 6 months and older to protect against influenza, while pneumococcal vaccines prevent serious bacterial infections causing pneumonia, meningitis and sepsis. On 1/21/2026 at 1:08 PM, a medical record review revealed the following:- Resident #62: admitted [DATE], the record lacked evidence that the pneumococcal vaccine was offered upon admission or thereafter.- Resident #57: Originally admitted [DATE] with a recent readmission on [DATE]; the record lacked evidence that pneumococcal and flu vaccines were offered. While the Director of Nursing (DON) stated consents were with the family, there was no documentation of vaccine refusal in the medical record. - Resident #45: admitted [DATE], the record lacked evidence that the pneumococcal vaccine was offered upon admission or thereafter. - Resident #9: admitted [DATE], the record lacked evidence that flu and pneumococcal vaccines were offered until 1/21/26, when consents were signed following surveyor intervention. On 1/22/2026 at 9:15 AM, a review of the General Immunization/ Vaccination policy (reviewed on 6/11/25), indicated the following:1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against infectious disease in accordance with national standards of practice2. Immunizations will follow current CDC guidance and scheduling based on specific vaccinations3. Residents, staff and volunteer workers will be offered immunizations against infectious disease as per current federal, state and local guidance.4. Residents, staff and volunteer workers will be screened prior to receiving any immunizations to ensure eligibility for the specific vaccines.On 1/22/2026 10:30 AM, the ADON/Infection Preventionist Nurse(ADON/IP) confirmed that pneumonia, flu, and COVID-19 vaccines were not routinely checked upon admission. Later that day, at 2:10 PM, vaccine declinations for Resident #57 (signed on 1/22/26 after surveyor intervention) were provided. Unit Manager (UM#2) confirmed that while immunizations are part of the admission process, they have not been completed consistently. On 1/23/2026 at 8:45 AM, the Nursing Home Administrator (NHA was informed of the concerns.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to offer and provide required education regarding the benefits, risks, and potential side effects of COVID-19 vaccine to residents and staff. This was evident for 3 (Registered Nurse RN #10, Geriatric Nurse Assistants GNA #10 and #11) staff members and 4 (Resident #57, #45 and #9) of 5 residents randomly reviewed for immunizations. The findings include: According to Centers for Disease Control (CDC), COVID-19 vaccines are recommended for individuals aged 6 months and older to protect against severe illness, hospitalization, and death. These vaccines work by training the immune system to recognize and fight the virus, with protection decreasing over time, making updated doses necessary especially for high risk groups.A) 01/20/2026 at 10:15, the surveyor requested 5 random employee health records, however, the Assistant Director of Nursing/Infection Preventionist Nurse (ADON/IP) stated, we don't require immunization for staff, whatever is in the employee file, that's it. The Director of Nursing (DON) was present during the conversation. On 1/20/2026 at 12:30 PM, an initial review of employee health records revealed that RN #9 with a hire date of 10/10/23, GNA #10 with a hire date of 3/19/25, and GNA #11 with a hire date of 11/1/22 showed no immunization record on their employee files. On 1/21/2026 at 11:19 AM, the DON and ADON/IP Nurse were notified of the concerns and acknowledged the findings. The ADON/IP Nurse reiterated that all the documents should be in the employee files. On 1/23/2026 at 1:20 PM, the Nursing Home Administrator (NHA) provided the surveyor with the list of employees that have immunization records on file. The surveyor informed the NHA that the 5 staff members that were randomly reviewed were not on the list except for 1 staff that had been previously recorded. On 1/23/2026 at 1:47 PM, while the ADON/IP Nurse provided the immunization records of these employees (GNA #10, GNA#11 and RN #9), the files contained no evidence that the COVID-19 vaccine had been offered, or the related education had been provided. B) On 1/21/2026 at 1:08 PM, medical record reviews revealed a lack of documentation regarding COVID-19 vaccine offers or education for the following:- Resident #57: No evidence of vaccine offer or education in the record. A declination was only signed on 1/22/2026 following surveyor intervention.- Resident #45: The record lacked evidence of both vaccine offer and education.- Resident #9: No evidence of vaccine offer or education was documented until 1/21/2026, when consents were signed following surveyor intervention. On 1/22/2026 at 9:15 AM, a review of the General Immunization/ Vaccination policy (reviewed on 6/11/25), indicated the following relevant sections:3. Residents, staff and volunteer workers will be offered immunizations against infectious disease as per current federal, state and local guidance.4. Residents, staff and volunteer workers will be screened prior to receiving any immunizations to ensure eligibility for the specific vaccines.8. Staff, volunteer workers, residents or resident representatives will be required to sign a consent form prior to administration of the vaccine(s). The completed, signed, and dated record will be filed in the individual's [NAME] record, or the staff or volunteer's medical file.10. The resident's medical record or staff/ volunteer's medical file will include documentation that the staff, volunteer, resident and/or the resident's representative was provided with education regarding the benefits and potential side effects of immunization(s), and that the resident received or did not receive the immunization(s) due to medical contraindication or refusal.On 1/22/2026 10:30 AM, the ADON/IP Nurse confirmed that pneumonia, flu, and COVID-19 vaccines were not routinely checked upon admission. Later that day, at 2:10 PM, vaccine declinations for Resident #57 (signed on 1/22/26 after surveyor intervention) were provided. Unit Manager (UM#2) confirmed that while immunizations are part of the admission process, they have not been completed consistently.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review and interview, it was determined that the facility failed to provide evidence that nursing staff have received required training on abuse prevention, neglect, and exploitation upon hire and annually. This was evident for 5 (Geriatric Nurse Assistant GNA# 8, #11, #10, Registered Nurse RN #9, and Licensed Practical Nurse LPN #12) of 5 randomly selected nursing staff reviewed for annual training requirements during the recertification survey. The findings include: On 1/16/2026 at 9:11 AM, during an interview with Staff #1, he/she stated that the Assistant Director of Nursing or Infection Preventionist (ADON/IP) Nurse serves as the facility's official Staff Educator. He/she added that staff training upon hire and annually was a collective effort involving the Director of Nursing (DON), the Nursing Home Administrator (NHA), and the ADON/IP Nurse/Staff Educator. On 1/21/2026 at 8:27 AM, a review of the nursing employee records revealed the following: 1. GNA #8 (hired 2/23/24): Completed a 7-item abuse quiz, however, the completion date was not recorded.2. GNA #11 (hired 11/1/22): No evidence of abuse prevention, neglect, and exploitation training upon hire and annually was on file.3. GNA # 10 (hired 3/19/25): Completed a 7-item abuse quiz, however, the completion date was not recorded.4. RN #9 (hired 10/10/23): Completed a 7-item abuse quiz, however, the completion date was not recorded.5. LPN #12 (hired 1/29/24): Completed a 7-item abuse quiz, however, the completion date was not recorded. On 1/21/2026 at 11:19 AM, the DON and the ADON/IP Nurse/ Staff Educator were notified and acknowledged these findings. The ADON/IP Nurse/ Staff Educator stated that the facility does not use an online learning platform, as all training is conducted via face-to-face in-services or classroom sessions. She confirmed that all relevant training documents were stored in individual employee folders and were not available elsewhere in the facility.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on record review and interview, it was determined that the facility failed to provide Quality Assessment and Performance Improvement (QAPI) training to staff. This was evident for 5 (Geriatric Nurse Assistant GNA# 8, #11, #10, Registered Nurse RN #9, and Licensed Practical Nurse LPN #12) of 5 randomly selected nursing staff reviewed during the recertification survey. The findings include: QAPI is a Centers for Medicare and Medicaid (CMS) program that merges proactive Performance Improvement (PI) with reactive Quality Assurance (QA). It requires nursing homes to use data-driven, systematic approaches to improve quality of care, resident safety, and overall quality of life. On 1/16/2026 at 9:11 AM, during an interview with Staff #1, he/she stated that the Assistant Director of Nursing or Infection Preventionist (ADON/IP) Nurse serves as the facility's official Staff Educator. He/she added that staff training upon hire and annually was a collective effort involving the Director of Nursing (DON), the Nursing Home Administrator (NHA), and the ADON/IP Nurse/Staff Educator. On 1/21/2026 at 8:27 AM, a review of the nursing employee records revealed no evidence of QAPI training for the following staff members:1. GNA #8 (hired 2/23/24)2. GNA #11 (hired 11/1/22)3. GNA # 10 (hired 3/19/25)4. RN #9 (hired 10/10/23)5. LPN #12 (hired 1/29/24) On 1/21/2026 at 11:19 AM, the DON and the ADON/IP Nurse/ Staff Educator were notified and acknowledged these findings. The ADON/IP Nurse/ Staff Educator stated that the facility does not use an online learning platform, as all training is conducted via face-to-face in-services or classroom sessions. She confirmed that all relevant training documents were stored in individual employee folders and were not available elsewhere in the facility.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on record review and interview, it was determined that the facility failed to provide mandatory infection prevention and control training to staff upon and hire and routinely thereafter. This was evident for 5 (Geriatric Nurse Assistant GNA# 8, #11, #10, Registered Nurse RN #9, and Licensed Practical Nurse LPN #12) of 5 randomly selected nursing staff reviewed during the recertification survey. The findings include:On 1/16/2026 at 9:11 AM, during an interview with Staff #1, he/she stated that the Assistant Director of Nursing or Infection Preventionist (ADON/IP) Nurse serves as the facility's official Staff Educator. He/she added that staff training upon hire and annually was a collective effort involving the Director of Nursing (DON), the Nursing Home Administrator (NHA), and the ADON/IP Nurse/Staff Educator.Guideline #16 of the facility's Infection Prevention and Control Program Policy (reviewed/ revised 1/7/25) indicated the following: Staff Education a. All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function.b. All staff shall demonstrate competence in relevant infection control practices.c. Direct care staff shall demonstrate competence in resident care procedures established by our facility.However, a review of the nursing employee records on 1/21/2026 at 8:27 AM revealed:1. GNA #8 (hired 2/23/24): No evidence of training on file.2. GNA #11 (hired 11/1/22): No evidence of training on file.3. GNA # 10 (hired 3/19/25): Completed hand hygiene quiz on 6/14/25 and Targeted Infection Prevention Program: Indwelling Urinary Catheter Care, however, the completion date was not recorded. No further evidence of training.4. RN #9 (hired 10/10/23): Completed hand hygiene quiz on 6/9/25 and Targeted Infection Prevention Program: Indwelling Urinary Catheter Care, however, the completion date was not recorded. No further evidence of training.5. LPN #12 (hired 1/29/24): Completed hand hygiene quiz and Targeted Infection Prevention Program: Indwelling Urinary Catheter Care, however, the completion dates were not recorded. No further evidence of training.On 1/21/2026 at 11:19 AM, the DON and the ADON/IP Nurse/ Staff Educator were notified and acknowledged these findings. The ADON/IP Nurse/ Staff Educator stated that the facility does not use an online learning platform, as all training is conducted via face-to-face in-services or classroom sessions. She confirmed that all relevant training documents were stored in individual employee folders and were not available elsewhere in the facility.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on record review and interview, it was determined that the facility failed to provide compliance and ethics training to staff. This was evident for 5 (Geriatric Nurse Assistant GNA# 8, #11, #10, Registered Nurse RN #9, and Licensed Practical Nurse LPN #12) of 5 randomly selected nursing staff reviewed during the recertification survey. The findings include: On 1/16/2026 at 9:11 AM, during an interview with Staff #1, he/she stated that the Assistant Director of Nursing or Infection Preventionist (ADON/IP) Nurse serves as the facility's official Staff Educator. He/she added that staff training upon hire and annually was a collective effort involving the Director of Nursing (DON), the Nursing Home Administrator (NHA), and the ADON/IP Nurse/Staff Educator. On 1/21/2026 at 8:27 AM, a review of the nursing employee records revealed no evidence of compliance and ethics training for the following staff members. 1. GNA #8 (hired 2/23/24)2. GNA #11 (hired 11/1/22)3. GNA # 10 (hired 3/19/25)4. RN #9 (hired 10/10/23)5. LPN #12 (hired 1/29/24) On 1/21/2026 at 11:19 AM, the DON and the ADON/IP Nurse/ Staff Educator were notified and acknowledged these findings. The ADON/IP Nurse/ Staff Educator stated that the facility does not use an online learning platform, as all training is conducted via face-to-face in-services or classroom sessions. She confirmed that all relevant training documents were stored in individual employee folders and were not available elsewhere in the facility.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, it was determined that the facility failed to provide the required 12 hours of annual in-service training for nurse aides. This was evident for 3 Geriatric Nurse Assistants (GNA# 8, #11, and #10) of 3 randomly selected GNAs reviewed for trainings during the recertification survey. The findings include: On 1/16/2026 at 9:11 AM, during an interview with Staff #1, he/she stated that the Assistant Director of Nursing or Infection Preventionist (ADON/IP) Nurse serves as the facility's official Staff Educator. He/she added that staff training upon hire and annually was a collective effort involving the Director of Nursing (DON), the Nursing Home Administrator (NHA), and the ADON/IP Nurse/Staff Educator. On 1/21/2026 at 8:27, a review of the employee records revealed no evidence of training on file for the following GNAs: 1. GNA #8 (hired 2/23/24)2. GNA #11 (hired 11/1/22)3. GNA # 10 (hired 3/19/25) On 1/21/2026 at 11:19 AM, the DON and the ADON/IP Nurse/ Staff Educator were notified and acknowledged these findings. The ADON/IP Nurse/ Staff Educator stated that the facility does not utilize an online learning platform, as all training is conducted via face-to-face in-services or classroom sessions. She confirmed that all relevant training documents were stored in individual employee folders and were not available elsewhere in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215134	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hartley Nursing and Rehab	1006 Market Street Pocomoke City, MD 21851

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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on record review and interview, it was determined that the facility failed to provide the mandatory behavioral health training program for all staff members upon and hire and annually. This was evident for 5 (Geriatric Nurse Assistant GNA# 8, #11, #10, Registered Nurse RN #9, and Licensed Practical Nurse LPN #12) of 5 randomly selected nursing staff reviewed during the recertification survey. The findings include: On 1/16/2026 at 9:11 AM, during an interview with Staff #1, he/she stated that the Assistant Director of Nursing or Infection Preventionist (ADON/IP) Nurse serves as the facility's official Staff Educator. He/she added that staff training upon hire and annually was a collective effort involving the Director of Nursing (DON), the Nursing Home Administrator (NHA), and the ADON/IP Nurse/Staff Educator. On 1/21/2026 at 8:27 AM, a review of the nursing employee records revealed: 1. GNA #8 (hired 2/23/24): No evidence of training on file.2. GNA #11 (hired 11/1/22): Completed a Dementia Overview on 10/21/25; however, there was no evidence of training upon hire or annually.3. GNA # 10 (hired 3/19/25): Records contained quizzes for Dementia (Ethics and Capacity, Palliative/End-of-Life Care, and Middle Stage), but completion dates were not recorded.4. RN #9 (hired 10/10/23): Completed Dementia Overview on 10/21/25 but lacked evidence of annual training. Quizzes for Dementia topics were found without recorded completion dates.5. LPN #12 (hired 1/29/24): Records contained Dementia topic quizzes, but completion dates were not recorded. On 1/21/2026 at 11:19 AM, the DON and the ADON/IP Nurse/ Staff Educator were notified and acknowledged these findings. The ADON/IP Nurse/ Staff Educator stated that the facility does not utilize an online learning platform, as all training is conducted via face-to-face in-services or classroom sessions. She confirmed that all relevant training documents were stored in individual employee folders and were not available elsewhere in the facility.