STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215144	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Mountain Rehab Center	141 South Main Street Boonsboro, MD 21713

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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 a pertinent document review and interviews, it was determined that the facility failed to provide an Emergency Medical Service (EMS) transport crew with the correct Medical Orders for Life-Sustaining Treatment (MOLST) for a resident being transported to the hospital, This deficient practice contributed to the resident not receiving life-sustaining treatment prior to cardiac arrest and resulted in the resident's death during transport. This was evident for one (Resident #200) of one resident reviewed for an unexpected death during a complaint survey. Consequently, an Immediate Jeopardy was called on [DATE] at 3:26 PM.The findings included:A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used to document a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient.On [DATE] at 8:00 AM, a review of complaint #2981632 revealed that on [DATE], an EMS crew responded to a 911 call placed by Resident #200. Prior to transport, the EMS crew was not provided with the correct MOLST form for Resident #200; instead, they were provided with the MOLST form belonging to Resident #200's roommate (Resident #201).On [DATE] at 12:00 PM the survey team received the facility's final report of their internal. Review of the report revealed the following.Resident was anxious, GNA reported to the nurse that resident was short of breath. The nurse went to the resident's room. The resident did not appear short of breath. Vital signs checked and were within normal limits. O2 sat was 93% on 2 liters nasal cannula. and s/he kept removing the oxygen, so the nurse stayed with the resident until s/he was comfortable and stopped removing his/her oxygen. Continued review of the facility's internal investigation revealed that the Deputy arrived and went to the resident's room with the nursing supervisor. The resident was unable to convey why s/he called 911. The deputy asked the resident if she wanted to go to the hospital and s/he stated yes. The deputy radioed for an ambulance at that time. EMS arrived and asked why s/he was going to the hospital. The Nurse reported her complaint of shortness of breath and desire to be transferred to the hospital. EMS left with the resident. Nurse reported s/he appeared calm and comfortable with an oxygen sat of 94% as s/he went by her on the stretcher. On [DATE] at 8:30 AM, the [NAME] County EMS incident report #2610270 was reviewed. The review revealed that Resident #200 called 911 and reported to the first arriving officer, a deputy, that they wished to go to the hospital. The deputy requested EMS, and upon arrival, the EMS crew prepared the resident for transport. Further review confirmed that the EMS crew documented that they did not receive the correct medical documentation for Resident #200, but instead received Resident #201's medical documentation, including the MOLST form.Continued review of the EMS report revealed the following: Staff made no effort to come to the room, leave the desk or help the crew, but did present EMS with the face sheet and MOLST. MOLST said Resident #201. Resident 201 as well as name tag on room. Patient is called by the name of (Resident #201 name) and does not correct EMS. On [DATE] at 9:36 AM, the Director of Nursing (DON) provided Resident #200's medical (paper) chart. A review of the chart revealed a MOLST form dated [DATE] with an order for DNR-A-2. This designation, Comprehensive Efforts to Prevent Arrest, requires that prior to cardiac arrest, staff (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	administer all indicated treatments to stabilize the resident, including medications and limited ventilatory support such as CPAP or BIPAP, while not initiating resuscitation in the event of cardiac arrest.At 9:42 AM on [DATE], a review of the SNF/NF to Hospital transfer form dated [DATE] revealed a section titled Copies of Documents Sent with the Resident/Patient. Although the MOLST form was listed as one of seven documents to accompany the resident, none of the listed documents were indicated as having been sent.On [DATE] at 1:36 PM, a review of Resident #201's (the roommate's) medical (paper) chart revealed a MOLST dated [DATE] with an order for DNR-B. This designation, Palliative and Supportive Care, directed that prior to cardiac arrest, only passive oxygen and comfort measures, such as pain relief, were to be provided and prohibited additional interventions including medications, intubation, CPAP, or BIPAP.A continued review of EMS records on [DATE] at 10:00 AM revealed that the treatment provided to, or withheld from, Resident #200 during transport was based on the DNR-B MOLST orders belonging to Resident #201, rather than Resident #200's own DNR-A-2 MOLST orders. As a result, Resident #200 did not receive the comprehensive interventions intended to prevent cardiac arrest that were consistent with their physician orders. Resident #200 experienced cardiac arrest during transport and was pronounced deceased at the hospital.On [DATE], an interview with the Quality Assurance EMS Captain revealed that upon arrival at the hospital, the EMS crew provided hospital staff with the documentation received from the facility. Hospital staff reviewed the documentation and informed the EMS crew that it did not belong to Resident #200. The EMS Captain reported that the crew had the capability to provide comprehensive care consistent with DNR-A-2 orders; however, those interventions were not initiated due to the incorrect MOLST orders provided by the facility. The EMS Captain also reported that they reviewed the 911 call, which confirmed that Resident #200 requested assistance. This was corroborated by the deputy, who confirmed the resident requested transport to the hospital.On [DATE] at 10:39 AM, the facility Administrator, DON, and Clinical Regional Manager were interviewed. They reported that the unusual circumstances, including the resident independently calling 911 and a deputy arriving prior to EMS, may have contributed to confusion regarding the resident's documentation. They also stated that the 911 call center had notified the facility that EMS was dispatched.A review of the initial facility report revealed that the resident was documented as DNR; however, the facility failed to specify the resident's designation as DNR-A-2. The MOLST form does not include a generic DNR designation, but instead identifies specific No CPR options, including Option A-1, Option A-2, and Option B.On [DATE] at 11:00 AM, a review of the facility's internal investigation notes included an interview with Staff #6, who documented that the emergency room was notified of Resident #200's transport and subsequently informed by the hospital that an incorrect MOLST form had been sent. The notes indicated that, following notification-and after the resident had expired during transport-the correct MOLST form was faxed by the unit secretary.On [DATE] at 2:26 PM, the Nurse Unit Supervisor (Staff #3) who was working at the time of the transfer was interviewed. She reported that Staff #6 provided the documentation to the EMS crew and that she was unaware of any error. During the interview, Staff #3 stated she believed there was only one type of DNR designation and was unable to differentiate between the MOLST optionsXXX[DATE] at 2:37 PM Nurse (Staff #7) was interviewed about what she reviews on a resident's MOSLT form prior to signing off. Nurse #7 reported she would review the MOLST for dates and signatures. When surveyor asked, Are there different types of DNR orders, Nurse #7 answered,No .a DNR is a DNR. On [DATE] at 11:22 AM During an interview the survey team shared with the Regional RN Staff #4 that interviews were conducted with a staff nurse regarding the different types of DNRs. Staff #4 confirmed that they had recognized this knowledge deficit and have added this to their nurse MOLST education. Additionally, Staff # 4 reported they are considering bringing in a nurse consultant that could more concisely explain the intricacies of the MOLST form. On [DATE] at 11:30 AM, the Regional Nurse (Staff #4) was interviewed. She confirmed that the hospital notified the facility that the incorrect MOLST form had been sent and reported that the correct MOLST was subsequently provided. She further stated that the facility was informed that (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #200 had expired during transport On [DATE] at 3:30 PM, the Administrator was interviewed and confirmed awareness of the concerns and the Immediate Jeopardy determination.The facility submitted a plan to remove the immediacy on [DATE]th at 4:36 PM 2026. The facility's plan included. 1. Continuing education on the Facility's MOLST policy with all Licensed nurses. 2. The audit will be ongoing for 3 months and results will be sent to the Quality Assurance Performance Improvement committee. On [DATE] at 4:36 PM the facility was notified that the first plan was not accepted.A second abatement plan was submitted on [DATE] at 5:45 PM. This plan was approved and included the MOLST policy with a clarification that nurses will receive the education prior to returning to work. The facility's MOLST policy requires two people to check the MOLST prior to transport. On [DATE] at 1:15 PM a review of the plan was made. The facility was informed that they needed to add how they would educate nurses that were unavailable to immediate education. The facility identified the nursing the staff that had extended absence and a plan to ensure education prior to returning to work On [DATE] at 4:30 PM, the plan was verified and the IJ was abated. On [DATE] at 12:30 PM an extended survey was completed.