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	03/06/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview with facility staff, it was determined that the facility failed to maintain food service equipment in a manner that ensures sanitary food service operations to prevent possible foodborne illness. This was evident during the kitchen tour of the recertification survey. The findings include: A food-contact surface refers to any surface of equipment and utensils that typically comes into contact with food; or from which food may drain, drip, or splash onto food; or a surface that is usually in contact with food. Cross-contamination refers to the transference of harmful substances or pathogenic microorganisms to food by hands, food contact surfaces, sponges, cloth towels, kitchen equipment and/or utensils that have not been properly cleaned after contacting raw food and then touching ready-to-eat foods. Cross-contamination can also arise from inadequate dishwashing procedures that fail to effectively wash, rinse, sanitize, air-dry, and/or stored in sanitary conditions. On 03/04/2026 at 10:10 AM, surveyors conducted a tour of the kitchen with the Certified Dietary Manager (CDM). The following deficient practices and unsanitary conditions were identified:Ice Machine and Prep Sink 1. The interior and exterior surfaces of the ice machine were observed to be unclean. 2. The overflow cover of the prep sink was cracked, chipped and damaged 3. The overflow cover of the prep sink was cracked, chipped, and damaged. 4. The drain stopper of the prep-sink was broken preventing the vats from being filled with water. 5. The drain line of the prep-sink was leaking. 6. The floor sink covers were rusted and unclean.Coffee Machines 6. The prep table supporting the coffee machine exhibits multiple jagged holes preventing a smooth, cleanable surface. 7. The coffee machine drain line lacked a backflow prevention device.Hand Sink and Food Prep Areas 8. The hand sink was not properly sealed to the wall to provide a smooth and cleanable surface areas to prevent bacterial proliferation. 9. Nonfunctional ceiling-mounted heating furnaces were identified in the kitchen. Placements of Fountain Soda Bag in a Box on Wire Stand and Rolling Food Cart 10. The electrical panel doors in the kitchen were not maintained in a closed position exposing significant accumulation of dust, debris, and dirt. Canopy Hood Area 11. The laminated wooden panels wrapped around the prep table were warped and water damaged. 12. The walls and floors beneath the cooking equipment were unclean.Hand Sink and Prep Table by the Cookline 13. The caulking around the hand sink at the wall was torn off. 14. The drain stopper of the in-counter prep sink was nonfunctional.Dropdown Ceiling Area 15. The ceiling tiles were improperly fitted and exhibited accumulations of dust and debris. Walk - in Refrigerator 16. The compressor fan covers were unclean. 17. The walk-in refrigerator was had one light bulb requiring replacement. 18. The door gaskets were unclean. 19. The casters on the shelving units were rusty and unclean.Walk - In Freezer 2 20. Walk-in freezer 2 was nonfunctional and turned off. Walk - In Freezer 1 21. Compressor fan covers were unclean. Warewashing Area 22. The warewashing hand sink was not securely sealed to the wall. The caulking around the unit was torn off, creating large gaps between the wall and the hand sink. 23. The 3-compartment sink dump test failed. The floor drain overflowed with greywater onto the kitchen floor. A review of the last local Health Department inspection report revealed that the floor sink previously had a clogging issue. 24. The 3-compartment gooseneck faucets were not (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	securely fitted onto the unit. 25. The drain lines of the 3-compartment sink were manifolded. High-Temperature Conveyor Dish Machine 26. The wall behind the high-temperature conveyor dish machine was exposed. 27. The grouting around the [NAME] tiles underneath the dish machines was not smooth and unleveled. 28. The dish machine ventilation failed to capture steam and vapors escaping from both ends of the unit. 29. The ceiling tiles around the dish machine vent stacks with adjustable dampers were unfitted. 30. The chemical bucket was not elevated off the floor to facilitate cleaning. 31. The left feed catch drain line leaked greywater onto the top of the 30-gallon dish detergent drum and onto the kitchen floor. 32. Numerous fruit flies were observed beneath the pre-rinse area and on top of the 30-gallon dish detergent drum. 33. The unused garbage disposal drain line was placed on the floor at the back of the dish machine.Self-Closing Entrance Doors Missing Doorknobs 34. Two kitchen entrance doors were missing doorknobs, which prevented the doors from being opened into the kitchen. 35. The bumper guards on the wall behind the food carts were damaged.Throughout the Kitchen Areas 36. The paint on the kitchen wall was chipped and scrubbed off in various places. In addition, several ceiling tiles were stained from food/drink splashes.Food Contact Surfaces 37. The utility rolling food service carts were cracked and damaged preventing units to be properly cleaned and sanitized. At 11:30 AM, a follow-up tour of the kitchen was conducted with the Maintenance Director and Staff #5 to identify the findings listed above. Both the Maintenance Director and Staff #5 confirmed that the deficiencies will be addressed promptly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation and interviews, it was determined that the facility failed to ensure staff performed hand hygiene when entering and exiting a room in which a resident was on neutropenic precautions. This was evident for 1 (Resident #84) of 1 resident on neutropenic precautions reviewed during the initial screening process of the annual survey.The findings include:Neutropenic precautions are critical safety measures for individuals with low white blood cell counts (neutropenia) to prevent life-threatening infections. Key actions include strict hand hygiene, avoiding crowds and sick individuals, consuming only well-cooked foods, avoiding raw fruits and vegetables, and removing fresh flowers or plants from the environment.On 3/03/26 at 9:00 AM, the surveyor observed a sign posted on Resident #84's door indicating the resident was on neutropenic precautions.On 3/03/26 at 9:36 AM, the surveyor observed a geriatric nursing assistant (GNA #21) entering and exiting Resident #84's room without performing hand hygiene. The surveyor asked GNA #21 to explain the sign posted on the door indicating Neutropenic Precautions. GNA #21 stated, It is very important that we wash our hands before entering and when leaving the room. She further explained that the resident must avoid undercooked and raw foods, cannot have live plants, and staff should wear personal protective equipment (PPE) when providing direct care.The surveyor asked GNA #21 why she did not perform hand hygiene if it was so important. GNA #21 made a facial expression and stated, I forgot, and then stated, but I didn't provide direct care. The surveyor asked for clarification as to whether hand hygiene was only required if providing direct care. GNA #21 confirmed, No, we must always perform hand hygiene when entering and exiting the room.On 3/05/26 at 9:20 AM, an interview was conducted with the facility Infection Preventionist nurse (IP #8), who reported that she managed isolation precautions for residents. She stated that neutropenic precautions require staff to perform hand hygiene before entering the room.On 3/05/26 at approximately 1:13 PM, the surveyor notified the Director of Nursing that GNA #21 did not perform hand hygiene before entering or after exiting the room of Resident #84. The Director of Nursing confirmed that she should have known better and stated that hand hygiene is required when entering and exiting the room of a resident on neutropenic precautions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record review, it was determined that the facility failed to provide a clean, homelike environment. This was evident in 2 (Resident #4 and Resident #103) of 2 residents' rooms reviewed during the recertification survey.The findings include:1) On 03/04/2026 at 3:27 PM, Resident #103 expressed a complaint to the surveyor regarding the cold temperature of the room while resting in bed, utilizing a heavy blanket obtained from home. A family member seated next to the resident indicated that they had previously voiced concerns about the cold room temperatures and the inadequacy of the thin vinyl rolling window treatment in blocking sunlight.The surveyor inspected the window and determined that the corner of the windowsill exhibited significant damage. In addition, the warped window frame, where sealant had been previously applied showed evidence of torn material resulting in slow air drafts. The ambient room temperature measured with a calibrated stem thermometer, placed on the nightstand adjacent to the resident's bed, was recorded at 70.6 degrees Fahrenheit. At 3:30 PM, the surveyor interviewed the [NAME] unit Nurse Manager and the Administrator. These interviews revealed no complaints were filed from the resident or their family members regarding the room temperature or a request for the installation of an alternative window treatment to mitigate significant sun exposure. In addition, a review of the grievance logs, spanning from the resident's admission date in February through March of 2026, also confirmed that no complaints were documented.At 3:35 PM, both the Administrator and the Maintenance Director assessed the resident's room and confirmed that the windowsill would be repaired and a new window treatment would be ordered immediately.On 03/05/2026 at 3:45 PM, the surveyor conducted a follow-up assessment with the resident, who was observed seated in a chair without the heavy blanket next to a family member watching television. The resident confirmed that the room temperature was comfortable. The surveyor verified that the damaged windowsill had been repaired. However, a new window treatment had not yet been installed.2) On 03/05/2026 at 12:55 PM, the surveyor observed a large exposed wall underneath the hand sink in Resident #4's room where both the drywall and concrete blocks were separated from the wall, exposing the waterline behind the wall. At 2:30 PM, the Maintenance Director was provided photographs of the resident's room taken by the surveyor. The Maintenance Director confirmed that the wall required removal to access and repair the waterline. He confirmed that the wall underneath the hand sink will be repaired/replaced promptly.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interviews it was determined that the facility failed to provide a bed hold notice and hospital transfer documents to a resident and failed to provide written notice of the hospital transfer to resident's representative. This was evident for 1 (Resident #1) of 2 residents reviewed for hospitalization during the survey.The findings include:On 3/6/26 at 8:52 AM a record review of Resident #1's electronic health record revealed Resident #1 was transferred to the hospital on 2/25/26. Further review revealed that Resident #1's family representative was notified via telephone.On 3/6/26 at 9:47 AM in an interview, Licensed Practical Nurse (LPN #18) confirmed that the hospital transfer process was the same throughout the facility and described that once a physician order was obtained, the unit clerk prints and assembles pertinent medical records and places them into an envelope titled: Acute Care Transfer Document Checklist. The transferring nurse verifies the contents and sends the packet with the resident.On 3/6/26 at 10:38 AM the Unit Clerk (Staff #19) confirmed LPN #18's description of the hospital transfer process. She stated that the bed hold notice was in the resident's paper chart. She did not know who was responsible for notifying the family representative. I put the packet together, and give it to the nurse, I don't know what happens after that.On 3/6/26 at 11:00 AM a record review of Resident #1's paper chart revealed a lack of bed hold notice. LPN #18 confirmed the finding and stated, every resident should have one. The Director of Admissions stated that the Bed Hold notice is included in the admission packet. On 3/6/26 at 11:08 AM a review of the Hospital Transfer/bed hold policy revealed, in part, that when the facility transfers a resident, specific information is documented in the medical record, and the residents (or resident representatives) are notified.in writing. A record review of the Bed hold Policy Mailing to Responsible Party log did not include Resident #1's name which indicated that the resident's representative was not notified in writing.On 3/6/26 at 12:07 PM in an interview, the Director of Nursing and the Assistant Director of Nursing acknowledged that they cannot confirm that Resident #1 received the bed hold notice, hospital transfer documents nor that written notice of the transfer was provided to the resident representative.