STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215149	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denton Nursing and Rehab	420 Colonial Drive Denton, MD 21629

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of a closed and active medical record, reviews of all pertinent administrative records, and staff interviews, it was determined that the facility failed to have a system in place to ensure clinical records were complete and accurately documented. This was found to be evident for 2 (Residents #8, #9) of 9 residents reviewed during the complaint survey.The findings include:Documentation is an integral part of medication administration. Documentation communicates the timing, dosing, and effect of any medications received by a patient. In the setting of skilled nursing care, residents are often prescribed multiple medications for significant medical conditions. They are also often more vulnerable to medication errors and more prone to changes in condition that require review and adjustment of their medication regimen. Inaccurate medication documentation has the potential to place residents at significant risk of medication error, provide incomplete or inaccurate information for providers and care givers to evaluate, and represents a failure of basic medication administration principles.Late documentation is a form of inaccurate documentation and is worsened if the documentation does not document when medications were given. 'Late administration' is defined as giving medication greater than 1 hour after a medication is due. 'Late documentation' is defined as not documenting immediately after administration.A review of the facility Pain Management policy revealed a section named Pain, Management and Treatment, which included: #1 - Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission.1) Resident #8 was admitted to the facility on [DATE] with diagnoses that included but limited to: anxiety, dementia, and atrial fibrillation. The facility initiated a comprehensive care plan for pain management on 10/17/2023. The goal of the pain management care plan was: The resident will be free of any discomfort or adverse side effects from pain medication the review date. The Pain Management care plan was last revised/updated on 06/23/25. Nursing interventions included but were not limited to administering analgesic medications as ordered by physicians and monitor/document side effects and effectiveness every shift. Review of Resident #8's closed medical record on 12/01/25 revealed a controlled medication utilization record that was issued by the facility pharmacy on 10/27/25 for the pain medication, Morphine Sulfate 100 mg/5 ml, give 0.25 ml orally once a day, and give 0.25 ml orally as needed every 2 hours. A review of Resident #8's Morphine Sulfate controlled medication utilization record revealed 34 doses of Morphine Sulfate had been signed out in November 2025. A review of Resident #8 November 2025 medication administration record (MAR) revealed that only 26 doses had been signed off as being administered to Resident #8 in November 2025. The dates the nursing staff failed to document administering a dose of Morphine Sulfate to Resident #8 on the MAR Included the following:11/08/25 at 12 noon11/08/25 at 5 pm11/11/25 at 1 pm11/19/25 at 6 pm11/22/25 at 11 am11/22/25 at 3 pm11/22/25 at 6 pm11/23/25 at noonA further review of Resident #8's November 2025 (MAR) and the nursing progress notes failed to reveal any nursing documentation of a nursing assessment indicating these doses of Morphine Sulfate were effective or not.In a telephone interview with staff nurse #1 on 12/04/25 at 3:38 PM, staff nurse #1 stated that s/he was not aware of not signing off administering doses of Morphine Sulfate to Resident #8 in November 2025. Staff nurse #1 also stated that Resident #8 had a standing order (once a day) and a as needed order for Morphine Sulfate.2) Resident #9 was admitted to the facility on [DATE] with diagnoses that included but limited to: lumbar back pain, chronic pain, repeated falls, and muscle wasting and atrophy. Resident #9 started Hospice services on 10/09/25. The facility initiated a comprehensive care plan for chronic pain on 10/31/23. The goal of the pain management care plan was: The resident will verbalize adequate relief of pain or ability to cope with pain through the review date. The Chronic Pain care plan was last revised/updated on 01/29/24. Nursing interventions included but were not limited to anticipating the resident's need for pain relief and responding immediately to any complaint of pain.Review of Resident #9's closed medical record on 12/03/25 revealed a controlled medication utilization record that was issued by the facility pharmacy on 10/14/25 for the pain medication, Morphine Sulfate 100 mg/5 ml, give 0.25 ml every 4 hours as needed for restlessness. A review of Resident #9's Morphine Sulfate controlled medication utilization record revealed 35 doses of Morphine Sulfate had been signed out from 10/14/25 through 11/30/25. A review of Resident #9's October and November 2025 medication administration records (MAR) revealed that only 14 doses had been signed off