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	03/16/2026

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 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 record reviews and interviews it was determined that the facility failed to ensure that residents remained free of neglect. This was evident for 1 (Resident #75) of 1 Resident reviewed for neglect during the recertification survey. The findings include:During a review of Facility Reported incident #2730935 on 3/10/2026 at 8:35 AM it was revealed the incident was submitted to the Office of Health Care Quality on 1/30/2026. The incident reported an allegation was made by Resident #75 that no staff provided care to him/her during the 11p - 7a shift.During a review of the facility incident folder for incident #2730935 on 3/11/2026 at 10:46 AM a Follow-Up Investigation form was discovered that validated the allegation and reported it was confirmed that Geriatric Nursing Assistant (GNA) #12 did not go into the room of Resident #75 to provide care during the 11p - 7a shift on the shift of 1/29/2026. The facility noted the concern was a Verified allegation and that GNA #12 was disciplined.During a review of the GNA tasks documentation on 3/11/2026 at 11:32 AM it was revealed that there was no documentation for Bathing, Bed Mobility, Oral Hygiene, Toileting, Barrier Cream after incontinence care, Bowel Elimination, Urinary Incontinence or Foam Ankle Boots on in bed as tolerated being completed on 1/29/2026 for the 11p - 7a shift.During an interview with the Director of Nursing on 3/12/2026 at 8:28 AM she stated that care provided during the shift should be documented by the GNA. She confirmed that there should not be blank spaces on the GNA tasks documentation, she added refusals and anything related to the care the GNA provided should be documented. She reported that if the task wasn't documented she advised we don't have the support to show it was completed. She confirmed that if care was provided to Resident #75 on the night shift of 1/29/2026 then it should have been documented and not left blank.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record reviews and interviews, it was determined that the facility failed to thoroughly investigate allegations of neglect. This was evident for 1 (Resident #75) of 1 Resident reviewed for neglect during the recertification survey.The findings include:1. During a review of medical records for Resident #75 on 3/16/2026 at 9:25 AM a Hospital Consult Report had been uploaded into the medical records for Resident #75 on 12/13/2025. Upon reviewing the consultation report it was discovered that Resident #75 had went to the Emergency Department on 12/13/2025. The Emergency Department Provider Note stated the resident had complained that Resident #75 reported that he/she constantly has been getting neglected by the night shift 11p - 7a shift at the nursing facility and He/she frequently sits in his/her urine and says that they purposely ignore his/her call bell. This time, he/she called 911 for help.During an interview with the Administrator on 3/16/2026 at 9:38 AM he reported that he was not aware of the complaint that Resident #75 had made to the Emergency Department. He also advised that he was not aware of an investigation being conducted for this complaint. He confirmed that the Emergency Department Note found in the medical records for Resident #75 had been uploaded by staff from the nursing facility. He confirmed that the Administrator should be made aware of any reports of neglect and those concerns should be investigated.During an interview with the Director of Nursing on 3/16/2026 at 9:50 AM she reported that when a Resident returns from the hospital the admitting nurse would screen the resident and review discharge paperwork for discharge information and orders. She confirmed that the nurse that admitted Resident #75 should have reviewed the discharge paperwork and should have noted the resident's complaint of neglect.2. During a review of Facility Reported Incident #2690114 on 3/16/2026 at 9:56 AM it was discovered that Resident #75 had reported an allegation of neglect to the facility and being left in soiled conditions for an extended period.During an interview with the Director of Nursing (DON) on 3/16/2026 at 10:17 AM she reported she could not find the investigation file for incident #2690114 concerning Resident #75. She was able to provide documentation of the initial incident report that was submitted to the Office of Health Care Quality on 12/10/2025 at 5:15 PM. She was unable to find any additional files or documentation related to the incident.During an interview with the DON 3/16/26 at 10:58 AM she reported that a file would be kept containing any interviews or evidence that was obtained during an investigation of a Facility Reported Incident. She confirmed that Resident #75 should have an investigation folder for incident #2690114 but they were unable to find the investigation folder.During an interview with the Administrator on 3/16/26 at 10: 58 AM he confirmed the investigation notes and interviews from a facility reported incident would be kept in a folder which would be kept in a file cabinet. He advised the previous DON handled the investigation for incident #2690114 and confirmed that they were unable to find the investigation file.

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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 interviews and medical record reviews it was determined that the facility failed to ensure 1) quarterly care plan meetings with the interdisciplinary team were held and 2) a Residents care plan intervention was implemented. This was found to be evident for 2 (Resident #75 and #1) out of 18 Residents reviewed for care plans during the recertification and complaint survey. The findings include: 1) A Care Plan is used in nursing facilities to summarize a resident's health conditions and care needs. It is used to ensure resident's needs are met and consistent care is provided to the resident based on those needs. Care Plan meetings are meetings with a team of care providers (attending physician, a registered nurse with responsibility for the resident, nursing assistant with responsibility for the resident, dietary services, the resident, and the resident's representative if applicable) to ensure the plan is continually adjusted to meet the changing needs or concerns of residents. Care Plan meetings are required to be held quarterly. During an interview with Resident #75 on 03/10/2026 at 12:15 PM he/she denied having regular care plan meetings. During a review of medical records for Resident #75 on 3/11/2026 at 11:07 AM it was discovered that he/she had care plan meetings held on 12/04/2024, 9/17/2025 and 1/16/2026. There were no additional care plan meetings documented between the meetings held on 12/06/2024 and 9/17/2025. During an interview with the Regional Social Worker on 3/11/2026 at 12:52 PM she reported there were no care plan meetings held for Resident #75 between the care plan meetings that were held on 12/04/2024 through 9/17/2025. She confirmed meetings were missed and should have been held in March and June of 2025. 2) During a review of Resident #1's progress notes conducted on 03/11/26 at 9:15 AM, it was discovered that the Resident had multiple occasions where he/she displayed inappropriate sexual behavior. During a review of the Resident #1's Care Plan conducted on 03/11/26 at 9:22 AM, it was discovered that the Resident had a Care Plan for inappropriate sexual behavior with an intervention for a 1 to 1 supervision. During an observation of Resident #1 conducted on 03/11/26 at 10 :33 AM, the Resident was observed on the unit without 1 to 1 supervision. During an interview conducted on 03/10/2026 at 10:42 AM, The Surveyor asked Registered Nurse (RN) #10 if Resident #1 continued to have inappropriate sexual behavior. The RN reported that the Resident continued to display inappropriate behaviors with other Residents. When asked if the Resident had 1 to 1 supervision, the RN replied not presently. When asked when the last time the Resident had 1 to 1 supervision the RN stated that it had been a while maybe 2 months ago. When asked if the Resident had displayed inappropriate behaviors in the last 2 months the RN replied that the Resident had those behaviors daily. During an interview conducted on 03/13/26 at approximately 11:00 am, the Director of Nursing (DON) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged that Resident #1 displayed inappropriate sexual behavior and did not presently have a 1 on 1 supervision as noted in the care plan.

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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 observations, record reviews and interviews it was determine that the facility failed to provide Residents with quality of care. This was found to be evident for 5 (Resident #88, #39, #41, #47 and #90) out of 18 Residents reviewed for quality of care during the recertification and complaint survey. The findings include: 1) On 03/11/2026 at 10:02 AM, this surveyor observed Licensed Practical Nurse (LPN) #4 administer medications to Resident #88. When administering medications, LPN #4 did not explain the medications to the resident or offer the opportunity for the resident to be informed. On 03/11/2026 at 10:58 AM, this surveyor observed LPN #4 administer medications to Resident #40. LPN #4 did not explain the medications or offer the resident the opportunity to be informed. On 03/13/2026 at 8:42 AM, this surveyor observed Registered Nurse (RN) #5 administer medications to Resident #39 in a shared room with Resident #41 present. RN #5 did not provide privacy during the medication administration, as the privacy curtain was not drawn and Resident #41 was able to observe the process. On 03/13/2026 at 8:57 AM, record review of the facility's medication administration policy under Policy Explanation and Compliance Guidelines indicated Provide Privacy. On 03/13/2026 at 10:40 AM, this surveyor conducted an interview with the Director of Nursing (DON), who reported that staff are expected to offer residents the opportunity to be informed about their medications during administration, as this supports resident choice and the ability to refuse medications if desired. During the interview, the DON was informed of the above concerns, including failure to explain medications and failure to provide privacy during medication administration. The DON acknowledged and confirmed understanding of the concerns. On 03/16/2026 at 8:46 AM, this surveyor conducted an interview with the Administrator and communicated the concerns related to medication administration practices. The Administrator acknowledged and confirmed understanding. 2) On 03/10/2026 at 12:05 PM the surveyor observed two urinals filled with urine on top of the nightstand in Resident #47's room. The resident stated, Some of the aides empty it for me, and some don't. It depends on who is working. This happens all the time. On 03/10/2026 at 12:10 PM during room rounds, the surveyor observed a urinal filled with urine and a trash can sitting on the bed in Resident #90's room. During room rounds in 400-411 on 03/10/2026 at 12:15 PM, the surveyor observed a trash can under the sink that was approximately one-quarter full of coffee-colored water and trash. Resident #47 stated, Don't worry, it has been there for a couple of days. On 03/10/2026 at 12:44 PM during an interview, the Lead Geriatric Nursing Assistant (GNA) stated that GNAs empty residents' urinals during rounds, conducted every two hours and as needed. She confirmed that, while some residents may empty their own urinals, it is the responsibility of GNAs to ensure all urinals are emptied during the shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During room rounds on 03/11/2026 at 1:59 PM in room [ROOM NUMBER]-411, the surveyor and the Director of Nursing (DON) observed a trash can under the sink approximately one-quarter full of coffee-colored water and trash. The DON stated that it was 'probably left there to prevent water from leaking on the floor,' but acknowledged it was not supposed to be there and indicated that a work order was being placed immediately.