STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215198	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Health and Rehabilitation Center	154 North Artizan Street Williamsport, MD 21795

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review and staff interview, it was determined that the facility discharged their residents inappropriately. This was evident for 1 (#3) of 4 residents reviewed for discharge. The findings include:MDS (Minimum Data Set) - is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. On 5/6/26 at 10:00 AM a review of intake #2991200, revealed the complainant felt Resident #3 was inappropriately discharged home. A medical record review for Resident #3 on 5/6/26 at 10:08 AM a medical record review revealed an MDS with ARD of 4/8/26 that documented the resident had no cognitive impairment. On 4/20/26 a Notice of Medicare Noncoverage (NOMNC) signed by the resident documented the resident's last covered day was 4/22/26. A progress note written by Social Services Staff #8 on 4/21/26 revealed the resident appealed the decision, but the decision was upheld. She wrote another progress note on 4/22/26 that the resident appealed again and they were awaiting the results. The discharge MDS with ARD of 4/23/26 revealed the resident was a substantial to maximum assist for some ADLs and dependent on staff for mobility in and out of bed and for transfers between surfaces. On 4/23/26 Nurse Practitioner (NP) #10 documented a discharge summary that read the resident needed moderate to maximal assistance per the therapy note. He noted that they were offered a mechanical lift, but the family declined due to limited space in the home. He wrote that the resident had wounds that required wound care. He wrote that the resident needed to establish a primary care doctor in the community and that they were going home with home health services. The resident was discharged home on 4/23/26. However, there was no evidence in the record that home health services had been set up prior to the resident being discharged . On 5/6/26 at 10:41 AM an interview with the resident and a family member revealed they had no home health services, to include therapy services, set up prior to discharge. They reported it was a planned discharge because the resident's insurance was ending. They reported the resident was unable to move from one surface to another, it was difficult to bath and care for the resident. An interview with Social Services Staff #8 on 5/6/26 at 1:09 PM revealed that she had been working with the resident for a discharge because the insurance coverage was ending and they were unwilling to pay privately. She reported she faxed information on 4/23/26 to 2 home health agencies. She stated that the first one was unable to take the resident due to insurance. She then reached out to another agency but had not followed up to ensure that services were set up. She failed to ensure that the resident had the post-discharge services that they needed prior to their discharge date . On 5/7/26 at 10:08 AM an interview with Licensed Practical Nurse (LPN) #13 revealed she was aware Resident #3 was planning to go home on 4/23/26 because the resident told her goodbye on 4/22/26. Geriatric nursing assistant (GNA) #12, who worked on Resident #3's unit, was interviewed on 5/7/26 at 10:41. She reported that she knew the resident was going home on 4/23/26. She stated the resident was saying his/her goodbyes to the staff on 4/22/26. On 5/8/26 at 2:10 PM an interview with the home health agency revealed that they received the referral for Resident #3 on 4/23/26, however they had not provided services for the resident. She stated that they cannot provide services for a resident without a primary care doctor in (continued on next page)

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
	215198	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Health and Rehabilitation Center	154 North Artizan Street Williamsport, MD 21795

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the community which was the case with this resident. An interview with the Regional Social Worker Staff #9 on 5/7/26 at 1:58 PM revealed she was providing oversight of the Social Services Staff. The concerns were reviewed with her and she was asked if this was an appropriate discharge. She stated that she had no concerns with how Social Services Staff #8 set up Resident #3's discharge.During an interview with the Nursing Home Administrator on 5/6/26 at 3:02 PM she reported that the discharge was resident initiated. However, there was no evidence in the medical record or during interviews that this was the case.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215198	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Health and Rehabilitation Center	154 North Artizan Street Williamsport, MD 21795

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 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 interview, it was determined that facility staff failed to document a resident's discharge as required. This was evident for 2 (#3 and #4) of 4 residents reviewed for discharge. The findings include:1) A medical record review for Resident #3 on 5/6/26 at 10:08 AM revealed a discharge summary on 4/23/26 written by Nurse Practitioner (NP) #10 which noted the resident was discharged on 4/23/26. Further review revealed no discharge note was written by nursing to indicate how the facility staff provided a safe and orderly discharge. A review of the discharge instructions in the assessment tab revealed they had been completed by the Assistant Director of Nursing (ADON). A review of the document tab (documents that were uploaded into the computer) revealed discharge instructions were uploaded and had a handwritten note on them that they were given via telephone. There was no date/time or signature of who provided them over the phone. An interview with the ADON conducted on 5/7/26 at 10:25 AM revealed on the day of discharge staff were to print the discharge instructions, review them with the resident and the person taking the resident home, and have them sign the discharge instructions. She stated that the nurse should write a progress note about the discharge. When asked about Resident #3's discharge she stated that she completed the discharge instructions but had not discharged the resident that day. When asked who had, she stated she would find out and report back to the surveyor. She reported back that it was Licensed Practical Nurse (LPN) #11. LPN #11 was called and a message left to call back for an interview, but he failed to do so. The concerns were reviewed with the Director of Nursing on 5/8/26 at 2:31 PM. 2) On 5/6/26 at 11:56 AM a medical record review for Resident #4 revealed a progress note dated 4/21/26 that was written by Social Services Staff #8. The note read that she was asked to provide a 30-day discharge notice to the resident. However, she failed to document the reason for the discharge. Further review of the progress notes failed to reveal the reason the resident had been issued a 30-day notice. A review of the uploaded documents failed to reveal a copy of the 30-day discharge notice. An interview on 5/6/26 at 1:09 PM with Social Services Staff #8 revealed the resident was issued a 30-day discharge notice due to the failure to pay the facility for their services. When asked where the discharge notice was located in the medical chart she stated she was not sure. She reported she was not sure what she was required to document in the medical record regarding a discharge. The Regional Social Worker Staff #9 was interviewed on 5/7/26 at 1:58 PM. She stated that Staff #8 had appropriately documented the discharge because she noted the discharge notice was given. She stated that the reason for the discharge was on the 30-day discharge notice that was supposed to be uploaded into the medical record. However, it was not uploaded in the medical record until 5/6/26 after surveyor intervention. The concerns were reviewed with the Director of Nursing and Nursing Home Administrator on 5/8/26 at 3:05 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215198	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Health and Rehabilitation Center	154 North Artizan Street Williamsport, MD 21795

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 - 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 record review and interview, it was determined that facility staff failed to provide quality of care to their residents. This was evident for 1 (#1) of 1 resident reviewed for falls.The finding include:Neurological Assessments (neurochecks): an assessment conducted by nurses that includes a full set of vital signs (blood pressure, pulse, respirations, and temperature), check pupils for size and reaction to light, weakness on one or both sides, and level of consciousness. The purpose of the neurochecks is to monitor the resident for symptoms to indicate a brain injury following a fall in which the resident is known to have hit their head or if it is unknown.A medical record review for Resident #1 on 5/8/26 at 9:02 AM revealed a post fall assessment dated [DATE] that documented the resident had a fall, but the time of the fall was unclear. A review of the neurocheck assessment revealed that the nurse completed one for the required timeframes but failed to include a full set of vital signs for each neurocheck. Further review revealed a post fall assessment that documented the resident had a fall on 11/25/25 at 5:20 AM. Review of the neurocheck assessments revealed one assessment had been entered around 8:30 AM by LPN #6, but the rest were blank. Review of the vital signs tab revealed that this was the only vital sign entered for 11/25/25. On 5/8/26 at 2:18 PM Licensed Practical Nurse (LPN) #2, who was the nurse who cared for the resident on 11/21/25 reported that she writes the neurochecks on a sheet of paper at the time she conducts the assessment then later transcribes them to the computer. She stated that she could recall exactly what occurred on 11/21/25 but thought she may have forgotten to change the date and time for all the vital signs (because they auto populate to the last set of vital signs taken) for each assessment. However, she was unable to provide evidence that a full set of vital signs were obtained. An interview with LPN #6 on 5/8/26 at 12:34 PM, who was the nurse assigned to Resident #1 on 11/25/25, revealed she was unable to recall what had happened that day. She stated she normally writes the neurochecks on a cheat sheet and then entered them in the computer later. She stated she had not retained a copy of the neurocheck cheat sheet. On 5/8/26 at 2:18 PM an interview with LPN #5, the unit manager for the unit that Resident #1 resided on, was conducted. She reported that she would review all the post falls forms the next day that she was on duty to ensure that they were completed. However, she was unable to provide a rationale for the reason she had not reviewed this resident's falls. The concerns were reviewed with the Director of Nursing on 5/8/26 at 2:31 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215198	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Health and Rehabilitation Center	154 North Artizan Street Williamsport, MD 21795

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to ensure that their residents were free of accidents/hazards. This was evident for 1 (#1) of 1 resident reviewed for falls. The finding include:A medical record review for Resident #1 on 5/8/26 at 9:02 AM revealed a care plan for the resident's risk of falls that was initiated on 11/17/25. The goal was that the resident would not have an injury from a fall with 2 interventions in place; to keep commonly used items nearby and remind the resident to use the call light. The attending physician documented during a resident visit on 11/18/26 that the resident had dementia and abnormality with their walking. Review of the assessments revealed a post fall assessment was completed for the resident on 11/21/25. Facility staff documented that the resident was found on the floor near their bed. A review of the care plan for resident's risk of falls revealed staff updated it to read the resident had an actual fall on 11/24/25, 4 days after the resident's fall. The goal was not changed and the intervention added was to offer the resident to go back to bed after visitors leave. Further review of the assessment tab revealed the resident was found on the floor on 11/25/25. Further review of the care plan revealed facility staff added an intervention to keep the bed in the lowest position. A progress note written by Social Services Department read that the family wanted the resident discharged home on [DATE]. An interview with Resident #1's family member on 5/8/26 at 1:26 PM revealed that s/he was notified on 11/21/25 that the resident had fallen out of his/her wheelchair and then on 11/25/25 that the resident had fallen out of his/her bed. The family member reported that they felt facility staff had not checked on Resident #1 enough to prevent the falls. This was why the family decided to take the resident home on [DATE]. On 5/8/26 at 2:18 PM Licensed Practical Nurse (LPN) #5, who was the unit manager, revealed that she had no rationale why they failed to include the level of supervision needed to prevent the resident from falling. The concerns were reviewed with the Director of Nursing on 5/8/26 at 2:31 PM.