

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Dennett Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1113 Mary Drive Oakland, MD 21550	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>30428</p> <p>Based on observation, interview, review of facility reported incidents and facility policy, it was determined that the facility failed to treat a vulnerable resident with respect and free from verbal abuse. This was evident during a complaint survey and a random observation of staff and resident interactions (Resident #39).</p> <p>The findings include:</p> <p>1. During the tour and observation of resident care and staff activities on 3/3/25, Resident # 39 was observed at different times either rolling up and down the halls on all units in his/her wheelchair or scooting around on the floor on his/her buttocks. When the resident was observed on his/her buttocks previously staff had guided him/her back to his/her respective room where the resident stayed for a time before coming back out again scooting along the floor. This activity would occur repeatedly throughout the day.</p> <p>At approximately 1:06 PM Resident #39 was observed scooting up the hall from his/her room towards the nursing station. Staff GNA #5 at this time was heard saying here he comes again, he needs to be 1:1. At this time Resident #39 was in front of the nurse's station along with staff Licensed Practical Nurse (LPN) #3 and Geriatric Nursing Assistant (GNA) #4 and GNA #5. GNA #5 continued to state, Every freakin' hour, 365 (referring to Resident #39). Resident #39 was then picked up by GNA #5 and placed in his/her wheelchair. GNA #5 then stated, and off [s/he] goes to cause destruction to someone else, put [her/him] in the office to crawl around, [resident] will be fine, as Resident #39 turned and wheeled down the hallway. There was also another resident sitting in the immediate area, later identified as Resident #309</p> <p>The Director of Nursing (DON) and the Nursing Home Administrator (NHA) were immediately notified of the observations that occurred with GNA #5 and Resident #39.</p> <p>Record review on 3/3/25 at 2:00 PM revealed Resident #39 has a diagnosis including cerebral palsy, and unspecified intellectual disabilities. On 7/13/24 Resident #39 was assessed and documented as non-verbal. This was also observed throughout the survey. Review of the medical record for Resident #309 revealed diagnoses including cancer and adjustment disorder. A brief interview for mental status was conducted on 2/14/25 which revealed a score of 15 meaning that s/he is cognitively intact at the time of the incident.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 215216	If continuation sheet Page 1 of 5

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of GNA #5's employee file revealed that he had annual in-service training on abuse 11/11/24 and re-in-services that were held facility wide on 12/12/24.</p> <p>The concern related to GNA #5's outward verbalization of frustration related to the behaviors of Resident #39 and the lack of GNA #5's ability to provide appropriate interventions and interactions with Resident #39 secondary to his/her diagnosis of cerebral palsy was reviewed with the facility during exit on 3/5/25.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>30428</p> <p>Based on the review of a facility reported incident #MD00214913, #MD00214911 and #MD00213420, medical record review, interview with facility staff and review of facility policies, it was determined that the facility failed to ensure that residents medications were secure, maintained and free from misappropriation. This was evident for 2 of 3 (#1 and #17) residents reviewed for medication misappropriation. This was identified a D of past non-compliance for facility reported incidents MD00214913 and MD00214911 for F602.</p> <p>The findings include:</p> <p>Review on 3/3/25 at 10:30 AM of the facility reported incidents #MD00214913 and #MD00214911 revealed concerns related to narcotic discrepancies and misappropriation.</p> <p>According to facility reported incident #MD00213420 occurring on 1/9/25, a family brought medications from home to the facility for Resident #302, which included Ativan (sedative). Unfortunately, about a week or so after they were discharged home, they alleged that the Ativan bottle they brought home no longer contained Ativan but metformin (diabetic medication). They called the facility and complained. The facility did an investigation and was unable to determine if there was a mix-up with the medication but did implement new policies for residents bringing in medications from home. This also initiated the first round of education provided to the nurses regarding narcotic medications and the increase in audits of the narcotic logs by the Assistant Director of Nursing (ADON) and Director of Nursing (DON).</p> <p>Interview on 3/3/25 at 11:21 AM with the facility ADON revealed that the administration started to notice a pattern with a specific nurse, so they started to watch her and the narcotic logbook closely. It was during this audit that the DON and ADON found a questionable signature on a narcotic log from 1/3/25 that LPN #14 forged.</p> <p>'A pattern of incorrect documentation, missing forms, missing medication, and false documentation was identified by DON and ADON and later identified to only occur on the days when staff LPN #14 worked and completed the forms. They realized that the pharmacy sheets that came in and out were not matching and they found a pattern only where this specific nurse worked.'</p> <p>According to the facility investigation packet, reviewed on 3/3/25, LPN #14 was interviewed regarding the DON's findings and initially denied any wrongdoing but had confirmed that she signed another nurse's signature on one of the pharmacy narcotic forms.</p> <p>The facility's investigation determined that there was Tramadol (narcotic for moderate-severe pain) taken from Resident #1 and Gabapentin (anticonvulsant/nerve pain medication) from Resident #17.</p> <p>The facility implemented an ad hoc quality assurance and performance improvement meeting on 1/13/25 related to this concern of drug diversion with LPN #14.</p> <p>The plan included:</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate all nurses on the floor</p> <p>Do not accept any medications from a resident's home stock</p> <p>Two nurses need to sign for all narcotics that come into the building from pharmacy.</p> <p>Only the management team can destroy any controlled medications.</p> <p>The shift-to-shift count sheet must be completed every time the keys change hands even if the nurse leaves and goes out of the building for lunch.</p> <p>We are to use BLACK ink only</p> <p>DO not scratch out or write over any mistake made on the count sheets or shift to shift report. Cross out the mistake with one line initial and write error. DO not write over any numbers. If you write the wrong number put one line through it, initial it, write error and write the correct number.</p> <p>The shift-to-shift count sheets need to stay in the binders until collected by management.</p> <p>The controlled substance sheets, when completed need placed in the med room, in the allotted spot.</p> <p>Education for all nurses was completed on 2/28/25 according to the sign in log</p> <p>Observation of the narcotic logs with the ADON on the 100 unit on 3/3/25 at approximately 11:45 AM noted no concerns with the narcotic logs or the signatures. There were no noted holes or discrepancies for March or February for this log.</p> <p>On 3/4/25 at 8:35 AM Agency LPN #9 was interviewed regarding the process of completing the narcotic log, sign in and sign out with another nurse. She stated that you count the cards and the pills in the card and sign with the nurse.</p> <p>There was a new narcotic log implemented as per the ad hoc meeting and there were no concerns or holes or errors noted. This surveyor asked the process for discrepancies, and LPN #9 stated that they recount, look for the medication then immediately report to the ADON or DON.</p> <p>Interview with the DON on 3/5/25 at 10:37 AM regarding what initiated that concern with LPN #14 and the discrepancies. She stated the same as the ADON, that around 2/12/25 something seemed off. When they came in on 2/17/25 they did an audit and looked at the nurses' signatures and it appeared that one of the signatures was not that nurse's actual signature and that was the straw' then they realized paper was missing and others were remade by LPN #14.</p> <p>LPN #14 was terminated from the facility on 2/21/25.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>30428</p> <p>Based on observation, interviews, record reviews, and policy reviews, the facility failed to follow infection control and prevention guidelines as follows: The facility staff did not don (put on) personal protective equipment (PPE) prior to entering a resident room and providing hands on care. This was evident during the random observation of staff to resident interactions and patient care. This failure had the potential to affect the spread of infections and involved Resident (39)</p> <p>The findings include:</p> <p>During the tour of the facility and observation of resident and staff practices, on 3/3/25 at approximately 12:45 PM, this surveyor observed LPN #3 in the room of Resident #39, with Resident #39 and GNA #4. Resident #39 was due for nutrition to be administered via the gastrostomy tube (medical device that provides a direct route to the stomach for nutrition and medication). At this time s/he was very active and not responsive to the requests from LPN #3 to sit and let her administer the fluid bolus. GNA #4 was attempting to hold Resident #39's right arm and they both hollered for assistance. GNA #5 then came to the room to assist with the feeding administration. When LPN #3 saw this surveyor at the door observing the event in Resident #39's room, she yelled for the door to be closed. This surveyor waited outside the door until all 3 staff members exited the room.</p> <p>Upon exiting the room, this surveyor asked what PPE the 3 of the staff wore while providing care. LPN #3 stated we had our gloves</p> <p>and masks on, did you see he was flailing trying to head butt me?</p> <p>It was reviewed at that time that there was an Enhanced Barrier Precaution sign on Resident #39's door and no one was wearing the appropriate PPE, which included according to the sign and the facility policy to the donning of gowns prior to the interaction with Resident #39s' gastrostomy tube, especially if they knew the potential of his/her behaviors and potential rejection of care that LPN #3 reported upon exiting the room.</p> <p>The DON and NHA were notified of the observations during the survey and again during exit on 3/5/25.</p>		