STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215216	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dennett Rehab Center	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)
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. Based on interview, record review, and facility policy review, the facility failed to ensure a nurse followed a physician's order for wound care for 1 (Resident #3) of 3 sampled residents reviewed for wound care.Findings included: A facility policy titled, Wound Care, revised 10/2010, revealed, 12. Remove dry gauze. Apply treatments as indicated. The policy specified, 2. Report other information in accordance with facility policy and professional standards of practice. An admission Record revealed the facility admitted Resident #3 on 04/20/2026. According to the admission Record, the resident had a medical history that included a diagnosis of dementia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2026, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had skin tear(s). Resident #3's Order Recap Report for the timeframe 04/01/2026 - 06/30/2026, revealed an order dated 05/01/2026 to cleanse the skin tear on the resident's left forearm with wound cleanser, pat dry, and apply a transparent dressing and leave in place until it falls off. Resident #3's hospital record dated 05/20/2026, revealed Pt [patient] has wounds to bilateral forearm that are not dressed. During an interview on 06/09/2026 at 12:02 PM, Registered Nurse (RN) #2 stated Resident #3 had skin tears on both of their arms. RN #2 stated the resident's skin tears appeared better, scabbed over, and dry at the time the resident was sent to the hospital. RN #2 stated the previous nurse left the skin tears opened to air. During an interview on 06/09/2026 at 12:48 PM, Geriatric Nursing Assistant (GNA) #8 stated Resident #3 had geri-sleeves applied because of skin tears on their arms. GNA #8 stated she recalled the nurse mentioned during a prior shift that she removed the dressing from the resident's skin tears to allow the skin tears to dry out. During an interview on 06/09/2026 at 12:27 PM, Licensed Practical Nurse (LPN) #4 stated Resident #3 had two skin tears on their arms. LPN #3 stated she removed a transparent dressing from one of the resident's skin tears because the dressing kept the skin tear too wet. LPN #4 stated she cleansed the resident's skin tear and left it opened to air so it could dry, even though the order indicated to leave the transparent dressing in place until it fell off. During a follow-up interview on 06/11/2026 at 12:55 PM, LPN #4 stated she should have called the physician and got an order to discontinue the dressings to Resident #3's arm so that the skin tear would be opened to air. During an interview on 06/11/2026 at 3:46 PM, the Assistant Director of Nursing (ADON) stated that if a skin tear was healing and the treatment needed to be changed, the nurse should document it on the skin sheet and notify the physician to get an order to discontinue or change the treatment. The ADON stated the nurse would not be following the plan of care if they did not replace the dressing according to the physician order. During an interview on 06/11/2026 at 2:21 PM, the Nurse Practitioner stated that if a resident had a treatment that needed to be changed due to skin healing, the nurse should call and discuss it with the provider. During an interview on 06/12/2026 at 10:50 AM, the Director of Nursing (DON) stated skin tear dressings should not be left opened to air without a physician order. The DON confirmed that when a nurse determined a treatment needed to change, the nurse should notify the provider, update the treatment plan, and obtain a new order.

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