

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/21/2026
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 observations, interviews, record reviews, and review of facility investigative records and witness statements, the facility failed to provide adequate supervision and implement appropriate interventions to prevent elopement for 1 of 3 sampled residents (Resident #5) who was identified as being at risk for elopement. As a result, Resident #5 eloped from the facility and was located walking on a main road before being safely returned to the facility. The findings include: Record review conducted on 7/20/26 at 11:45 a.m. of the admission Record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of dementia, cerebral infarction, hypertension, urinary tract infection, senile degeneration of the brain, age-related cataracts, restlessness and agitation, and hoarding disorder. Record review conducted on 7/20/26 at 1:47 p.m. of the History and Physical dated 6/16/26, completed by MD16 revealed Resident #5 had severe dementia, a history of cerebrovascular accident (CVA), hoarding disorder, and cataracts. The History and Physical documented Resident #5 was upset about being admitted to the facility, was ambulatory without an assistive device, and was a limited historian. Record review conducted on 7/20/26 at 1:53 p.m. of the Elopement Evaluation Assessment completed on 6/16/26 at 12:17 a.m. by LPN12 revealed the assessment documented Home Elopement History - No, Wanders - Yes, Goal Directed - Yes, Safety - No, Privacy - No, and Recent admission - Yes, with an elopement risk score of 5.0. Record review conducted on 7/20/26 at 1:55 p.m. of the Baseline Care Plan initiated on 6/16/26 by LPN12 Resident #5 was independent with ambulation and required no physical assistance for mobility. Record review conducted on 7/20/26 at 2:00 p.m. of the June 2026 Medication Administration Record (MAR), documented by LPN12, revealed a physician's order dated 6/16/26 for a Wander Guard bracelet with instructions to check placement and function every shift. Documentation indicated the Wander Guard was applied on 6/16/26 at 6:30 p.m. and the function was documented as checked on 6/16/26 at 6:30 p.m. and again on 6/17/26 at 6:30 a.m. Record review conducted on 7/20/26 at 2:08 p.m. of the Nurses' Progress Note dated 6/17/26 at 1:07 a.m., documented by LPN12 revealed Resident #5 became irritated, wanted the power of attorney, put on a coat, picked up a backpack, and stated, I am going home. The note further documented Resident #5 walked through the East Wing looking for a telephone and looking for a door to exit. The resident's family was contacted by telephone, after which Resident #5 became calm and rested in the room. Interview conducted on 7/20/26 at 2:18 p.m. with GNA8 revealed Resident #5 repeatedly stated on 6/17/26, I want to go home, throughout the day. GNA8 stated Resident #5 ambulated independently, wore a Wander Guard bracelet, and paced throughout the facility. GNA8 stated the last time Resident #5 was observed before the Code [NAME] was at approximately 3:00 p.m., after assisting Resident #5 to the restroom. Review conducted on 7/20/26 at 4:18 p.m. of a Facility Witness Statement dated 6/17/26, completed by the Human Resources Assistant (HRA), (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: 215216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed that at approximately 1:30 p.m., Resident #5 came to the front door and pushed on the door; however, it did not open. Resident #5 then walked away. The Receptionist stated that was the last time Resident #5 was observed until the elopement incident occurred. During interview on 7/21/26 at 10:47am, HRA indicated that on 6/17/26 Resident #5 walked to the front area of the facility, and was just talking to staff and other residents, and would walk back towards the hall. HRA stated that about 1:30pm, Resident #5 came back to the front area, went towards the main entrance door, wander guard alarm went off, tried to push on the door, and when it did not open, turned around, and went back walking down the hall. Review conducted on 7/20/26 at 4:18 p.m. of a Facility Witness Statement dated 6/17/26, completed by Activities Director (Act Dir), revealed that between approximately 2:00 p.m. and 2:15 p.m., Resident #5 asked if the resident could go outside. Act Dir walked with Resident #5 through the hallway to the blue double doors leading to the main dining room. Activities were playing bingo in the dining room, and the doors were closed. Act Dir attempted to open the doors but could not. Act Dir told Resident #5 that the resident could not go outside. Resident #5 then proceeded toward the last doors, when GNA8 intervened and started walking toward the [NAME] Wing with Resident #5. Act Dir then proceeded to the office to attend to paperwork and stated that was the last time Resident #5 was observed before the elopement. Review conducted on 7/20/26 at 4:18 p.m. of an additional Facility Witness Statement dated 6/17/26, completed by Receptionist, revealed Resident #5 came to the front, walked to the main door, the alarm activated, Resident #5 pushed onto the front door, and it did not open. Resident #5 then walked away. The statement documented that this occurred at approximately 1:30 p.m. and was the last time the receptionist observed Resident #5 until the elopement incident occurred. Review conducted on 7/20/26 at 4:18 p.m. of an additional Facility Witness Statement dated 6/17/26, completed by the Receptionist, revealed the Receptionist received a telephone call informing the facility that Resident #5 was walking down Broadford Road. The caller described the resident as wearing yellow pajamas. The Receptionist identified the resident as Resident #5. The Receptionist confirmed the description of Resident #5, announced Code Green, exited the facility with another staff member, and ran toward Broadford Road until locating Resident #5 with the caller. The statement documented Resident #5 was assisted into a staff member's vehicle and returned to the facility. During interview conducted on 7/21/26 at 12:16 pm, the Receptionist revealed that at approximately 1:20 p.m., Resident #5 approached the front entrance door and pushed onto the door. The Receptionist stated the Wander Guard alarm activated, and the door did not open. The Receptionist stated Resident #5 appeared a little agitated and walked away down the hallway. The Receptionist further stated that at approximately 3:20 p.m., they received a telephone call from another resident's family member, who asked if the facility was missing a resident. The Receptionist stated they replied that they did not think so. The receptionist stated that the other resident's family member then described the resident as wearing yellow pajamas. The Receptionist stated they immediately recognized Resident #5, ended the telephone call, picked up the facility phone, and announced Code Green, patient outside three times overhead. The Receptionist stated GNA10 responded, and they ran toward Broadford Road and located Resident #5 on [NAME] Drive. The Receptionist stated the other resident's family member remained with Resident #5 until facility staff arrived. The Receptionist stated the other resident's family member had been walking toward the facility when they observed Resident #5 and contacted the facility. The Receptionist stated GNA10 and LPN9 arrived, assisted Resident #5 into a vehicle, and transported the resident safely back to the facility. Review conducted on 7/20/26 at 4:18 p.m. of a Facility Witness Statement dated 6/17/26, completed by LPN9, revealed that after hearing the Code [NAME] announcement, LPN9 responded outside toward Broadford Road. The statement documented Resident #5 was located approximately (continued on next page)		

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 07/21/2026
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	450 feet from the facility with a member of the public. Resident #5 was assisted into LPN9's vehicle and returned to the facility. Upon returning to the facility, Resident #5 was assessed and no apparent injuries were noted. During an interview on 7/20/26 at 2:31 p.m., Licensed Practical Nurse (LPN)9 indicated they were an agency nurse who had been assigned to the facility since March 2026. LPN9 stated they provided care to Resident #5 on 6/17/26. LPN9 indicated Resident #5 was confused, knew only their name, ambulated independently without an assistive device, and was physically active, frequently walking throughout the facility. LPN9 stated Resident #5 had a Wander Guard device in place upon admission. LPN9 indicated they observed Resident #5 speaking with the resident's son by telephone and noted the resident was demanding during the conversation. LPN9 stated attempts at reality orientation were unsuccessful. LPN9 indicated Resident #5 did not exhibit exit-seeking behaviors and did not make statements that caused staff to believe the resident intended to leave the facility. LPN9 stated they observed Resident #5 walking from the therapy area toward the nursing station at approximately 2:45 p.m. before the resident returned toward their room. LPN9 indicated a Code [NAME] was announced at approximately 3:20 p.m., at which time staff immediately initiated a search of the facility and surrounding grounds. LPN9 stated they searched the area outside the facility by vehicle and located Resident #5 outside the building with a family member of another resident. LPN9 indicated Resident #5 remained standing, was pleasant, denied pain when assessed, had no visible injuries, and continued to wear the Wander Guard device. LPN9 stated Resident #5 willingly entered LPN9's vehicle after Geriatric Nursing Assistant (GNA)10 approached the resident and encouraged the resident to return to the facility. LPN9 stated Resident #5 commented, It's beautiful out here. Look at the flowers. Upon returning to the facility, Resident #5 underwent a head-to-toe assessment and skin assessment, with no injuries identified. LPN9 stated Resident #5 was placed on one-to-one supervision until discharge to a sister facility with a memory care unit at approximately 7:00 p.m. LPN9 further indicated that while repairs to the exit door were being completed, a staff member was assigned to continuously monitor the affected exit door, nurses verified the remaining exit doors were functioning properly, and there had been no additional elopements since the incident. During interview on 7/20/26 at 2:44 p.m., Geriatric Nursing Assistant (GNA)10 indicated they observed Resident #5 on the day of the incident ambulating independently throughout the facility without an assistive device. GNA10 stated that at approximately 3:00 p.m., they were attending a stand-up meeting when a Code [NAME] was announced. GNA10 indicated staff were informed that Resident #5 had been observed on [NAME] Road after a family member of another resident contacted the facility. GNA10 stated they and two Assistant Directors of Nursing (Registered Nurse (RN)20 and RN21) immediately exited the front entrance of the facility and proceeded toward the right side of the building and the parking lot. GNA10 indicated Licensed Practical Nurse (LPN)9 arrived in a personal vehicle after locating Resident #5. GNA10 stated Resident #5 was standing with a family member of another resident near the first house on the left side of Broadford Road. GNA10 indicated Resident #5 appeared pleasant, mumbled about the weather, ambulated at the resident's baseline, had no visible injuries, and did not complain of pain. GNA10 stated they asked Resident #5 to ride back to the facility, and the resident willingly entered LPN9's vehicle. GNA10 stated the family member who remained with Resident #5 did not report any concerns regarding the resident's condition. Upon returning to the facility, Resident #5 was placed on one-to-one supervision. GNA10 indicated the facility also assigned staff to continuously monitor the affected exit door, increased the frequency of elopement drills to every shift, and installed secondary audible door alarms (screamers) on the same day as an additional safety measure. Interview conducted on 7/21/26 at 10:55 a.m. with RN13 revealed that after the Code [NAME] was announced, RN13, GNA10, and Receptionist (continued on next page)		

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 07/21/2026
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	responded toward Broadford Road. RN13 stated Resident #5 was located near the second house before Broadford Road and was technically on [NAME] Drive when staff located the resident. RN13 stated Resident #5 got into the vehicle with LPN9 and GNA10 and was returned to the facility. RN13 further stated that upon returning to the facility, RN13 immediately began trying to determine how Resident #5 had exited the building. RN13 stated that RN13 and SSD17 inspected the exit door located on the 600 Hall. RN13 stated the door was not closed securely. Although the door appeared to be latched, when it was pushed, it opened. RN13 stated they closed the door, and when it was closed again, it latched and did not open. RN13 stated the alarm did not activate when the door initially opened. RN13 further stated no alarm had activated for that door. RN13 stated they held the door closed for approximately 15 seconds, after which the alarm activated, and the door did not open. RN13 stated the alarms activated appropriately on the other exit doors, but not on the 600 Hall exit door. Interview conducted on 7/20/26 at 1:56 p.m. with the Maintenance Director revealed the Maintenance Director inspected all ten exit doors each morning before staff arrived and inspected the doors at approximately 7:30 a.m. on 6/17/26. The Maintenance Director stated all exit doors, magnetic locks, the Wander Guard system, and door alarms were functioning appropriately during the morning inspection. The Maintenance Director further stated that following the Code Green, the exit door located on the 600 Hall of the Far East Wing was found ajar. The Maintenance Director stated the door timer was believed to have malfunctioned, preventing the magnetic lock from securing properly. The Maintenance Director stated the Regional Maintenance Director was notified, responded to the facility on 6/17/26, repaired the door, and confirmed the locking mechanism was functioning properly. Review conducted on 7/20/26 at 4:16 p.m. of the facility's corrective action documentation dated 6/17/26 revealed Resident #5 was immediately placed on one-to-one supervision upon returning to the facility pending transfer to a secured memory care unit. The documentation further revealed the Wander Guard placement and function were rechecked; the resident's care plan and elopement risk assessment were reviewed and revised; all exit doors were inspected; secondary exit alarms were installed on all exit doors; staff received re-education regarding the facility's Wandering and Elopement/Missing Resident Emergency Procedure; and daily Code [NAME] drills were initiated. Record review conducted on 7/20/26 at 4:16 p.m. of the Care Plan initiated on 6/17/26 by the interdisciplinary team revealed Resident #5 was identified as an elopement risk/wanderer related to dementia. The Care Plan documented Resident #5 agreed to wear a Wander Guard. Interventions included checking the Wander Guard placement and function as ordered by the physician, providing one-to-one supervision until placement in a secured memory care unit was arranged, distracting Resident #5 from wandering through pleasant diversions and structured activities, and assessing internal factors when increased wandering was observed. Record review conducted on 7/20/26 at 4:16 p.m. of the Social Services documentation dated 6/17/26, completed by SSD17 revealed Resident #5's responsible party agreed to transfer Resident #5 to a facility with a secured memory care unit. The documentation further revealed Resident #5 was discharged later that day and transferred without incident. During interview conducted on 7/21/26 at 12:23 p.m. with the Administrator, it revealed that the facility reviewed new admissions each morning and knew Resident #5 had been admitted from home. The Administrator stated that at approximately 3:20 p.m., while staff were in a stand-down meeting, an overhead page announced the emergency response. The Administrator stated they did not leave the building but were informed that Resident #5 had been safely returned to the facility. The Administrator stated the resident's family and physician were notified and that Resident #5 did not sustain any injuries. The Administrator stated the facility immediately began investigating the incident and determined the 600 Hall exit door was involved. The (continued on next page)		

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 07/21/2026
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administrator stated staff were assigned to continuously monitor the door until repairs could be completed. The Administrator further stated the Regional Maintenance Director, who lived nearby, responded to the facility and worked with the door vendor to evaluate and repair the door. On 7/21/2026, a past compliance Immediate Jeopardy was signed by the administrator. The facility implemented measures effective for supervision and elopement prevention for all residents with cognitive impairment and /or exit seeking behaviors. Review of the corrective action to correct non compliance indicated that on 6/17/26 at approximately 3:20pm the receptionist received a phone call from another resident's family member stating a lady was outside the center. Receptionist was able to identify the lady as Resident #5 and announced a code green (elopement). On 6/17/26 at approximately 3:24pm LPN9 and GNA10 were able to locate Resident #5 on the pathway towards Broadford Road, accompanied by another resident's family member. LPN9 together with GNA10 (who had arrived at location) returned Resident #5 back to facility via LPN9's car, after LPN9 assessed resident at the location found and determined that Resident #5 had no visible injuries, no complaints of pain, was stable but with confusion. At 3:25pm on 6/17/26 Resident #5 was returned to the facility and a skin assessment, including vital signs, was performed by LPN9 with no injuries notes. Wander guard was checked and revealed to be functioning appropriately. On 6/17/26 at 3:25pm, one on one staff monitoring was immediately initiated for Resident #5. On 6/17/26 at 3:30pm, the facility immediately implemented a 100% head count in the facility with all residents accounted for. Wander guard placed on 6/16/26 (admission) was rechecked and found to be working appropriately, care plan was updated, elopement binder was updated. Resident #5's elopement risk assessment was reviewed and revised to ensure accuracy and appropriateness of interventions. All emergency exit doors were inspected for proper functioning by ADON, maintenance staff and members of management team, with one door noted on 600 hallway not to be functioning consistently, and Regional Maintenance Director contacted and arrived onsite with technical issue corrected. All exit doors continued to be monitored by staff. Designated staff member assigned to the affected door on 600 hall until technical issue corrected. On 6/17/26 Regional Maintenance Director arrived on site and fixed technical issue to the affected door. On 6/17/26 at 5:30pm to 6:00pm secondary alarms were placed on all exit doors to ensure continued coverage in the event of a door. On 6/17/26 at 6:45 pm, after facility consulting with Resident #5 representative, Resident #5 was discharged from the facility to another facility with a secured unit for continued safety. On 6/17/26 the facility initiated Systemic Changes to Prevent Recurrence. The facility implemented the following system-wide interventions: Staff were interviewed to create a timeline as to when resident was last seen, with resident noted to have been toileted minutes prior to phone call being received. Re-education was initiated with all staff regarding Wandering and Elopement/Missing Resident Emergency Procedure. Care plans of residents identified at risk for elopement were reviewed and revised if needed. Residents with wander guards to have placement and function checked each shift for one week. The facilities Ongoing Monitoring and Quality Assurance. The facility conducted ongoing audits to ensure compliance: Vendor scheduled to be on site on 6/18/26 to perform inspection of door that had a malfunction to confirm in proper working order. Audit of all egress doors scheduled to be completed by vendor on 6/29/26 or sooner based on vendor availability. Re-education to be completed regarding Wandering and Elopement/Missing Resident Emergency Procedure prior to the employee's next shift worked. Elopement drills will be completed Daily for every shift for one week. Then weekly x 3 weeks. Results of these audits were reviewed in the Quality Assurance and Performance Improvement (QAPI) program. Any identified issues were addressed promptly with corrective action by facility. On 7/20/2026 from 11:30am to 2:44pm, eight staff were interviewed (Housekeeping HSK3, Geriatric Nursing Assistant GNA4, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/21/2026
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Occupational Therapist Assistant COTA5, Maintenance Director, Dietary Manager, GNA8, LPN9, GNA9). All eight staff stated that the facility completed code green (elopement) drills every shift for a month, and currently twice a week, confirmed receiving and were able to reiterate education regarding wandering and elopement/missing resident emergency procedure. Based on the above actions taken by the facility and verified by the surveyor on site, it was determined that the facility's deficient practice was past non compliance with a compliance date of 6/17/2026.		