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	03/16/2026

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation and staff interviews, it was determined that the facility failed to employ a qualified kitchen manager and/or a full-time dietician to execute the functions of the food and nutrition service. ServSafe is an accredited food and beverage training and certificate program administered by the US National Restaurant Association. The goal is to prevent foodborne illnesses based on a set of guidelines to improve safety and hygiene in food preparation.To become a Certified Dietary Manger (CDM), one must complete and pass an exam through an accredited program administered by the Association of Nutrition and Foodservice Professionals.The findings include:On 3/11/26 at 10:04 AM during observation of the kitchen, Surveyor observed the Kitchen Manger directing/instructing other kitchen staff to perform kitchen tasks. The Kitchen Manager (Staff #16) identified herself as the Kitchen Manager.During an interview, she acknowledged that she lacked qualifications and stated, I have to complete ServSafe and my CDM program. She reported that she communicates with a dietician twice a week, Tuesday and Thursday via email. On 3/12/26 at 11:23 AM, in an interview, the Nursing Home Administrator (NHA) stated that the certified dietician was never on site, she's not local to the area. She also acknowledged that the current Kitchen Manager (Staff #16) lacked training and qualifications for the role; I know we're getting a tag. Dietary is a challenge.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215216	A. Building B. Wing	03/16/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interviews, food tray sampling, and observation, it was determined that the facility failed to provide food that was appetizing in temperature, palatability, and flavor. This was evident during random resident interviews and food tray sampling. This had the potential to impact all residents.Findings included:On 3/11/26 at 11:59 AM, during an interview, Resident #7 reported that the food served at the facility was poor. The chicken was described as tough and difficult to cut.On 3/11/26 at 10:19 AM, Resident #8 reported that food portions were small. During a subsequent interview on 3/12/26, the resident reported that the food, specifically the meat, was overcooked.On 3/13/26 at 9:50 AM, the resident council president, Resident #81, was interviewed. The resident reported that concerns had been shared during resident council meetings indicating that the food was often cold and not good.On 3/16/26, an observation of lunch tray delivery was conducted. The tray was loaded onto the food cart at 11:46 AM and left the kitchen in route to the dining room at 12:17 PM. The tray was delivered at 12:26 PM, approximately 40 minutes after the food left the steam table.On 3/16/26 at 12:28 PM, three surveyors observed and tasted the lunch tray, which consisted of pork slices, rice, and a vegetable dish. Observation revealed that the food was no longer warm and was not palatable in temperature or taste.On 3/16/26 at 12:46 PM, three residents in the dining room were interviewed regarding the lunch meal. Two of the three residents reported they did not like the food. Resident #52 reported that the rice was undercooked and did not taste good. Resident #16 reported not liking the meat. Observation of Resident #16's plate showed that only a small amount of meat had been eaten; most remained on the plate, which had been pushed away.On 3/16/26 at 12:49 PM, these concerns were discussed with the Certified Dietary Manager Consultant (Staff #26). The consultant confirmed that the delivery time of the food trays between leaving the kitchen and arriving in the dining room was excessive. The consultant stated that delivering each cart as it became ready, rather than waiting for all the carts to be ready, could reduce the time between removal of the food trays from the steam table and service to residents.On 3/16/26 at 1:30 PM, these concerns were discussed with the administrator, who reported having reviewed the issue with the Certified Dietary Manager Consultant and approved the proposed plan to reduce food delivery time.

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	03/16/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to store and prepare food in accordance with professional standards for food service safety. This was evident by unsanitary conditions and unlabeled food items throughout the kitchen and storage areas observed during the kitchen survey. The findings include:On 3/11/26 at 9:00 AM, the surveyor observed color-coded labels with the printed acronym [NAME] (received, opened, expired). None of the labels included the date to indicate received, opened and expired.On 3/11/26 at 10:00 AM, the surveyor and Staff #16 observed the entire kitchen and multiple storage areas.During the observation, Staff #16 verbally acknowledged the following:None of the labels included the date to indicate received, opened, and expired on most, if not all, items.A approximate sized 4'X4' patch of ice was on the freezer floorFrozen condensation on the condensing unitThe oven and stove top had significant grease and food build-upFood debris and trash was accumulated in the tracks of the cook preparation tableBoth the primary and secondary steam tables' water was contaminated with food debrisThere was juice standing in the bottom of the automatic juice dispenserThe vent covers had grease, dust build-up, and one vent had an lodged insect.There was brownish/greenish buildup on walls and ceilingsA soaking-wet mop was observed in a dirty bucket in a mop sink; there were no drying hooks to hang the mop On 3/12/26 at 8:06 AM in an interview, the Nursing Home Administrator (NHA) and the Kitchen Manager confirmed the above were a concern.

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	03/16/2026

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and staff interviews, it was determined that the facility failed to maintain safe operating kitchen equipment. This was evident for the steamer equipment observed during the kitchen survey.On 3/11/26 at 10:04 AM during observation of the kitchen, it was observed that the steamer's on indicator light was dark and that no heat emanated from the steamer. In an interview, the Kitchen Manager (Staff #16) confirmed it hasn't worked for quite a while. She stated that she had verbally reported the broken equipment to the maintenance director.On 3/12/26 at 8:06 AM, during an observation of the kitchen with the Nursing Home Administrator (NHA), it was noted that the on indicator light appeared to be on.In an interview, Staff #16 reported, it doesn't work right. When you open the door hot water spills out. It's not safe.The NHA heard and acknowledged the concern.

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	03/16/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, it was determined that the facility failed to ensure resident dignity was maintained. This was evident for 1 (Resident #74) of 1 Resident observed for dignity.The findings include: On 03/15/26 at 8:20 PM, during an evening observation, the surveyor observed Resident #74 in their bed from the hallway. The resident was unclothed, uncovered, and fully exposed. No direct care was being provided to the resident during this observation. No curtain was pulled for resident privacy or dignity. The surveyor stood further down the hallway, observing from a distance as three facility staff passed Resident #74's open door, where they remained exposed until approximately 8:35 PM.On 03/15/26 at 8:45 PM, during an interview with the nursing home administrator, they were made aware of the concern regarding Resident #74's dignity.

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	03/16/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interviews, it was determined that the facility failed to ensure a system was in place to review, communicate, and implement pharmacy recommendations following a physician response. This was identified for 5 of 6 residents (#'s 17, 46, 27, 7, 66), reviewed for unnecessary medications.The findings include: 1.On 3/12/26 at 9:00 AM, a review of physician orders for Resident #17 revealed an order for Risperdal Oral Solution 1 mg/mL (risperidone), give 1 mg by mouth every morning and at bedtime for dementia. On 3/12/26 at 10:57 AM, review of the pharmacist's monthly medication review (MMR), dated 2/12/26, identified a recommendation stating the resident was receiving Risperdal for dementia without a diagnosis to support use. The pharmacist noted acceptable indications include schizophrenia, delusional disorder, bipolar disorder (mania), depression with psychotic features, and other psychotic disorders. On 3/12/26 at 10:59 AM, further review of the MMR revealed the physician documented okay and signed the recommendation on 2/12/26. On 3/12/26 at 12:05 PM, interview with Staff #24 (Psychiatric CRNP) confirmed the recommendation was reviewed; however, changes were documented only in a progress note and were not transcribed into physician orders. On 3/12/26 at 12:08 PM, record review identified a diagnosis of delusional disorder dated 1/15/26; however, the physician orders and MAR were not updated to reflect this diagnosis, and the indication was not available to the pharmacist at the time of the MMR. On 3/13/26 at 8:36 AM, interview with the consultant pharmacist (Staff #2) confirmed that accepted recommendations are expected to be reflected in physician orders and the MAR. On 3/12/26 at 12:42 PM, interview with the Director of Nursing (DON) confirmed that physician orders were not updated following acceptance of the pharmacist's recommendation. The DON stated that going forward, all MMR recommendations would be reviewed and incorporated into physician orders when accepted. 2. On 3/12/26 at 1:40 PM, review of physician orders for Resident #46 revealed an order dated 3/5/26 for Risperdal oral tablet, give 3 mg by mouth twice daily for agitation and aggression. On 3/12/26 at 8:59 AM, a request was made for the previous four MMRs. Review of these MMRs revealed no pharmacist recommendations addressing the use of Risperdal. On 3/13/26 at 10:17 AM, interview with the Medical Director (Staff #8) confirmed that the indication for Risperdal was under review and stated a preference to review pharmacy recommendations at the time they are made. On 3/13/26 at 10:50 AM, a follow-up review of physician orders revealed a revised order with a start date of 3/12/26 for Risperdal oral tablet 2 mg, give 3 mg by mouth twice daily for psychotic disorder (continued on next page)

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	03/16/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related to traumatic brain injury 3. On 3/12/26 at 4:04 PM a review of Resident #27's medical record revealed pharmacy recommendations dated 2/13/26, 12/08/25, and 7/18/25. No other pharmacy recommendations were found in the resident's record. The Director of Nursing (DON) was asked to provide the lists from the pharmacist of the residents for whom the pharmacist had no specific recommendations, for each of the past 12 months. On 3/13/26 at 9:08 AM, a review of the lists of residents for whom the pharmacist had no recommendations for the past 12 months, failed to reveal Resident #27's name for August 2025, November 2025, December 2025. The DON was asked to provide the specific pharmacy recommendations for these 3 months for Resident #27. On 3/13/26 at 10:32 AM an interview was conducted with the facility's Medical Director in the presence of the Nursing Home Administrator (NHA). The Medical Director said she became the medical director in December 2025. When asked about her process and preference of how pharmacy recommendations were reviewed, she indicated that it was her preference to review all of them, and added that if a pharmacy recommendation was provided to her she would review and response to it. On 3/13/26 at 11:08 AM, the DON provided pharmacy recommendations for Resident #27 for August 2025, November 2025, and December 2025. A review revealed that the August 2025 recommendation stated that a clear/appropriate diagnosis was needed for the medication atorvastatin. The form lacked any physician response, rationale, or signature. A review of the November 2025 pharmacy recommendation revealed the same request from the pharmacist as the August recommendation and indicated it was a second request, and the form lacked any physician response/rationale or signature. A review of the December 2025 pharmacy recommendation, revealed a request from the pharmacist to consider a reduction in the dose of the resident's proton-pump inhibitor (PPI) , a medication that reduces stomach acid production, but no response or rationale was provided although the form was signed by a physician. When asked, the DON said she was aware of the deficiency. 4. On 3/13/26 at 9:00 AM a review of Resident #7's medical record failed to reveal pharmacy reviews for May 2025, and September 2025, and December 2025. The DON was asked to provide these documents. On 3/13/26 at 11:28 AM, a review of the documents requested revealed that the May 2025 pharmacy recommendation, which recommended gradual dose reduction (GDR) attempt for Resident #7's antidepressant medication, failed to reveal any physician signature or response. A review of the September 2025 pharmacy recommendation which recommended a GDR attempt for a different antidepressant medication also failed to reveal any physician signature or response. A review of the December 2025 pharmacy recommendation which suggested a change in the resident's insulin dosage, was signed by a physician, but contained no response or rationale. The DON was interviewed and said she was aware of the deficiencies. 5. On 3/12/26 at 11:21 AM, a review of Resident #66's record revealed recommendations from the facility's consulting pharmacist on 1/06/26 that outlined irregularities in the diagnosis for the antipsychotic drug risperidone 2 mg for 'agitation'. The pharmacist recommendations to the prescribing provider recommended information on appropriate conditions for drug indication that aligned with the Diagnositic Statistical Manual (DSM)-V and the Centers for Medicare and Medicaid (CMS) guidelines for antipsychotic medications: Schizophrenia spectrum disorders (e.g., (continued on next page)

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	03/16/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schizophrenia, schizoaffective disorder, schizophreniform disorder), Delusional disorder, Bipolar I or II disorder with manic, mixed, or psychotic features, Major depressive disorder with psychotic features, Refractory major depression, Brief psychotic disorder, Psychotic disorder due to another medical condition (e.g., delirium with psychotic features), Other specified or unspecified schizophrenia spectrum and psychotic disorders. On 3/12/26 at 11:33 AM, an with Staff #24 (Psychiatric Certified Registered Nurse Practitioner) was conducted. Staff #24 explained they have been a consulting provider for the facility for a little over two years and comes on site to the facility once a week. When Staff #24 was asked about recommendations from the facility's consulting pharmacist regarding monthly medication reviews, they stated that they are completed within a week. On 03/12/26 at 11:37 AM, during the interview with Staff #24, the surveyor reviewed Resident #66's monthly medication recommendations from the facility's consulting pharmacist that outlined no clear or appropriate diagnosis for Resident #66's order of risperidone 2mg. Staff #24 explained that they are not aware of a timeframe the facility has for addressing monthly medication review recommendations, but that they are completed as soon as possible. Staff #24 referenced receiving reports from the pharmacy every couple of months, and based on previous gradual dose reductions, the stability of the resident or a change in condition, Staff #24 makes adjustments to medication orders accordingly. On 03/12/26 at 12:14 PM, there is no evidence that the prescriber made changes that were provided for Resident #66 on 1/6/26 or 2/13/26 related to the order for risperidone that is written as: RisperDAL Oral Tablet 0.5 MG (Risperidone), give 1 tablet by mouth two times a day for agitation. On 03/12/26 at 12:43 PM, the Director of Nursing (DON) was interviewed regarding monthly medication reviews and the findings related to Resident #66. The DON explained that they are responsible for updating orders when there are indications for proper use or proper diagnosis, and further explained that they have been in the DON role at the facility for approximately a week and a half at the time of the survey. On 03/12/25 at 12:50 PM, the DON acknowledged the concern regarding the prescriber's undocumented actions regarding recommendations provided by the facility's consulting pharmacist.

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	03/16/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and interviews it was determined that the facility failed to ensure resident records were kept private. This was evident when a resident's medical record (Resident #37) was left visible on a computer screen on 1 of 4 nursing stations observed after hours during the survey.The findings include:On 3/15/26 at 8:12 PM an observation of the 600/700 hallway of the facility was conducted. The nurses station was unoccupied at the time. A large computer screen on the desk was open to Resident #37's electronic chart and visible. On 3/15/26 at 8:18 PM an interview was conducted with the Activities Director (Staff #12) who had walked up to the surveyor who was still at the 600/700 nurses station. This surveyor asked Staff #12 to make a copy of the scheduled/assignment sheet and she proceeded to remove the schedule from the wall, brought it to the nurses station printer, which was located next to the computer screen with the resident's name showing, made a copy of the assignment sheet and gave it to the surveyor, then put the original schedule back on the wall.On 3/15/26 at 8:20 PM Staff #12 returned to the nurses station to continue the interview. When she was informed that the resident information was visible on the computer screen she paused for a moment and then went to the computer and locked the screen so the resident's information was no longer visible. On 3/15/26 at 8:37 PM an interview was conducted with the Nursing Home Administrator (NHA) in her office and when asked she said that there were no specified visiting hours, visitors were allowed at any time. The NHA was then informed that Resident #37's medical record was visible on the computer screen at the 600/700 nurses station and she acknowledged the finding.

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	03/16/2026

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 record review, observations, and interviews, it was determined that the facility failed to ensure physician orders were implemented. This was evident for 1 (Resident #1) of 5 residents reviewed for accidents during the survey.The findings included: On 3/11/2026 at 11:31 AM, Resident #1, admitted to the facility for rehabilitation, was interviewed. The resident had no documented cognitive impairment and reported doing well with no complaints regarding care.On 3/12/26 at 4:30 PM, a review of Resident #1's physician orders revealed the following order: apply Tubi grips to bilateral lower legs in the morning and remove at night, everyday shift, with a start date of 1/17/2026.On 3/12/26 at 5:05 PM, Resident #1 was observed sitting up in bed, talking with a visitor, fully dressed and wearing shoes. Observation revealed the resident was not wearing Tubi grip stockings.On 3/12/2026 at 5:10 PM, Nurse Staff #17 and the surveyor observed Resident #1's legs. Nurse Staff #17 confirmed that the resident was not wearing Tubi grip stockings. The nurse searched the room but was unable to locate the stockings. The nurse reported that the resident had been wearing the stockings that morning and stated that GNA Staff #18 and GNA Staff #19 may have removed them when providing care to the resident.On 3/12/26 at 5:15 PM, during an interview, GNA Staff #19 reported not removing the Tubi grip stockings from Resident #1.On 3/12/26 at 5:20 PM, during an interview, GNA Staff #18 reported assisting GNA #19 with care for Resident #1 and stated the stockings were not removed during their care on 3/12/26.On 3/12/26 at 5:22 PM, Nurse Staff #17 was interviewed and stated that if the GNAs did not remove the stockings, rehabilitation staff may have removed them during therapy.On 3/13/26 at 8:21 AM, the Physical Therapist Assistant (Staff #21) and the Occupational Therapy Assistant (Staff #20) were interviewed. Both reported providing therapy to Resident #1 on 3/12/26, including lower extremity exercises to improve strength and balance. They also reported that therapy goals included increasing independence with activities of daily living, as Resident #1 was unable to dress the lower extremities independently. Both staff members stated they did not remove the Tubi grip stockings.On 3/13/26 at 8:24 AM, during a continued interview, the Occupational Therapy Assistant (Staff #20) reported not recalling ever seeing Tubi grip stockings on Resident #1.On 3/13/26 at 8:32 AM, a review of the Treatment Administration Record revealed documentation that Tubi grip stockings were applied every morning from March 1 through March 12, 2026.On 3/13/2026 at 11:26 AM, Resident #1 was interviewed and asked if the stockings were worn that day. The resident reported yes, and stated it was the first time wearing them, also stating that they felt comfortable.On 3/13/26 at 10:11 AM, the administrator was interviewed regarding concerns with the Tubi grip stockings. The administrator reported that the resident was wearing the stockings on 3/13/26 and acknowledged concerns that the stockings had not been applied as ordered on previous days.

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	03/16/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, staff interviews, and record review it was determined that the facility failed to establish systems to accurately reconcile controlled medications using acceptable standards of practice. During observation of the facility narcotic books, it was observed that 2 of 3 narcotic count sheets did not accurately reconcile and document narcotic count during the survey.The findings includeThe standard of practice for narcotic reconciliation is conducted at the end-of-shift with two licensed personnel, the on-coming licensed personnel and the out-going licensed personnel, who verify the count of all controlled medications by signature on the narcotic count sheet.Reconciliation refers to a system of recordkeeping that ensures an accurate inventory by accounting for controlled medications. The reconciliation process identifies loss or potential diversion of controlled medications, minimizes the time between the actual loss or potential diversion and follow-up to determine the extent of loss. On 3/11/26 at 9:36 AM Licensed Practical Nurse (LPN #14) and this surveyor reviewed the East unit's narcotic count sheet. It revealed that LPN #15, the on-coming nurse, had signed the narcotic count sheet at 7:00 AM and at 6:30 PM as the out-going nurse. LPN #14 confirmed that the narcotic count sheet was prematurely signed. On 3/11/26 at 11:11 AM, in an interview, LPN #15 confirmed her signature and acknowledged that she had signed the narcotic count sheet dated 3/11/26 at 7:00 AM and at 6:30 PM and stated, I always sign early so that I don't forget.Further record review revealed a second narcotic count sheet that was undated and unlabeled. It lacked off-going licensed personnel signatures on 3/5 and 3/9/26.On 3/11/26 a review of the Controlled Substance Policy, Dispensing and Reconciling Controlled Substances revealed Nursing staff count controlled medication inventory at the end of each shift.The nurse coming on duty and the nurse going off duty make the count together and document.The Director of Nursing confirmed understanding that the facility's narcotic reconciliation practice failed to accurately reconcile and document controlled medications using acceptable standards of practice.

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	03/16/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview it was determined that the facility failed to ensure medications were secured and accounted for as evidenced by observation of a resident's medications which were left at the resident's bedside. Maintain and secure controlled medications in a separately locked, permanently affixed compartment. This was evident for 1 (Resident #2) during a random observation and 1 out of 3 refrigerators reviewed for medication storage during a surveyThe findings include:Controlled Medications are substances that have an accepted medical use, have potential for abuse, and may also lead to physical or psychological dependence. These medications fall under US Drug Enforcement Agency (DEA) Schedules II-V.1.) Resident #2 was re-admitted to the facility in February 2026 after a hospitalization for surgical repair of their fractured right hip. The resident's diagnoses included, but were not limited to, right neck of femur [hip] fracture and mild intellectual disability. On 3/15/26 at 8:04 PM an observation and interview with Resident #2 was conducted. The resident was seated in their wheelchair next to their bed with their overbed tray table in front of them. The table had a bowl of what appeared to be pudding, and next to the bowl was an overturned medicine cup and 6 pills that were loosely scattered on the table. When asked what the medications were, the resident pushed the pills around and pointed to one oblong pill and said I think that is my blood pressure pill. The resident could not specify what the other medications were. No staff were present in the room. A review of the resident's medical record revealed orders for the following medications to be administered at 9:00 PM: atorvastatin 20 mg (to reduce cholesterol), Montelukast 10 mg (for eczema), potassium chloride 10 mEq (for low potassium level), oxycodone 5 mg (a narcotic to treat pain), and pudding 1/2 cup to take medications. On 3/16/26 at 9:06 AM a review of the facility's medication administration policy dated April 2019, revealed a statement that said a resident may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. A review of Resident #2's physician order failed to reveal an order for the resident to self-administer their medications. The DON was asked to provide an audit of Resident #2's medication administration record for 3/15/26. On 3/16/26 at 11:58 AM an interview was conducted with the Director of Nursing (DON) to review the observation that Resident #2's medications were left on the resident's table and to review the resident's medication administration audit. The audit revealed documentation that Licensed Practical Nurse (Staff #11) signed that she administered the resident's 9:00 PM atorvastatin, Montelukast, potassium chloride, and oxycodone, in pudding at 9:01 PM. The DON confirmed the deficiency and also said that the facility would initiate disciplinary action for Staff #11 that day. 2.) On 3/11/26 at 2:21 PM Registered Nurse (RN #13) accessed the locked medication refrigerator on the [NAME] Unit. It was observed that the plastic box compartment contained Lorazepam (a controlled medication). The compartment was unaffixed. RN #13 easily removed the compartment and stated that it should be secured. On 3/11/26, the Director of Nursing (DON) provided the facility Policy for Controlled Substances (continued on next page)

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	03/16/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which stated, in part, controlled substances are separately locked in permanently affixed compartment. On 3/11/26 at 2:41 PM, the DON and Nursing Home Administrator confirmed the finding and acknowledged the concern.

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	03/16/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to ensure communication and collaboration on end of life care with the hospice agency. This was evident for 1 (Resident #78) of 1 residents reviewed for hospice and end of life care. The findings include:On 03/12/26 at 2:49 PM Resident #78's care plan indicated they were under Hospice of [NAME] County's care. Resident #78's care plan described they would have assistance with coping issues related to terminal illness and family would be provided emotional support to cope with the resident's decline and entry into Hospice. The care plan further indicated that the facility would update [NAME] County Hospice and the family of any changes, including significant changes, falls, and uncontrolled pain or discomfort.On 03/12/26 at 3:05 PM Resident #78's record was reviewed and revealed a progress note entered on 03/05/26 at 01:00 AM by Staff #4, a Licensed Practical Nurse (LPN), indicating: Resident #78 had been very agitated that evening. Resident #78 was yelling out in pain and requesting to go to bed. Staff members assisted Resident #78 to their to bed and made them comfortable with dignity maintained. Resident #78 continued to yell out saying, I need less pain, not more. Staff #4 administered ordered PRN doses of Morphine and Ativan, as well as a scheduled dose of Morphine. Resident #78 was resting comfortably with call bell in reach. There was no documentation that indicated the facility notified or provided an update to Hospice of [NAME] County. On 03/12/26 at 3:10 PM , a progress note entered on 03/06/26 at 10:55 AM indicated a change in condition related to Resident #78 having a unwitnessed fall, stating : [a laboratory technician] was coming up the hallway and stated that Resident #78 was starting to fall out of their bed. When staff reached the room, Resident #78 was partially on the floor and partially in the bed. Vital signs were taken and were stable. No new complaints of pain or discomfort. [Assisted] Resident #78 off floor and back into bed with no issues.There was no documentation that indicated the facility notified Hospice of [NAME] County of the incident.On 03/12/26 at 3:35 PM a telephone interview was conducted with Staff #6, a Registered Nurse (RN) from Hospice of [NAME] County, who indicated that they were Resident #78's case manager. Staff #6 stated that Staff #7, a Certified Nurse Aide (CNA), provided on-site visits to Resident #78 five days a week, and an RN provided on-site visits two days a week. Staff #6 reported that Resident # 78 had a fall at the facility on 03/06/26 at approximately 6:45 AM. Staff #6 explained staff #5, contacted them and provided an update on Resident #78's fall, and on that day of the event, 03/03/26, Staff #6 visited Resident #78. However, the most recent hospice visit note within Resident #78's medical record during the surveyor review and interview with Staff #6 was from 02/25/26. Further, the facility's progress note documentation in Resident #78's medical record did not indicate that the facility collaborated with or communicated with Hospice of [NAME] County regarding Resident #78's fall. During the phone call, the surveyor asked Staff #6 if they regularly attended the resident's care plan meetings as their case manager at the facility. Staff #6 said that hospice staff did not attend resident care plan conferences at the facility. The surveyor then reviewed with Staff #6 a care plan conference progress note for Resident #78 entered on 03/03/26, by Staff #10, the facility's social services designee, that explained Staff #7, who was in attendance stated Resident #78 would likely be coming off hospice services later that month. Staff #6 explained that Staff #7, a CNA, most likely knew this information from having been in communication with Staff #6. The surveyor asked Staff #6 if a CNA could make assessments and those types of determination statements, to which Staff #6 explained, No, they cannot.Resident #78's medical record did not indicate evidence of the facility having contacted, communicated or consulted with Hospice of [NAME] County related to events on 03/05/25 and 03/06/26. 03/13/26 at 11:40 AM ,during an interview, Staff #10 and the Nursing Home Administrator were made aware of the concern related to documented communication, collaboration, and consultation on Hospice and end of life care planning (continued on next page)

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	03/16/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between the facility and hospice agency. No additional evidence was provided before the end of the survey.

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	03/16/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined that the facility failed to ensure that licensed personnel used proper hand hygiene during medication administration to prevent and minimize the spread of infections. This was evident for two out of three licensed personnel (LPN #23 and LPN #25) observed during the medication administration task.Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involve the use of Personal Protective Equipment (PPE) such as gown and glove use during high-contact resident care activities.The findings include:On 3/11/26 at 4:00 PM the surveyor observed Licensed Practical Nurse (LPN #23) exit room [ROOM NUMBER], approach the hall medication cart, retrieve medication, re-enter the room and exit the room without proper hand hygiene.On 3/11/26 at 4:04 PM the surveyor observed LPN #23 assist Resident #56 to the restroom and to bed. An EBP sign and PPE hung on the door approximately 5' from the floor. The surveyor observed LPN #23 prepare Resident #56's medications, enter the room, administer the medications and exit the room without hand hygiene or donning PPE.On 3/11/26 at 4:20 PM the surveyor observed LPN #23 prepare Resident #8's medications, enter the room, administer the medications and exit the room without hand hygiene.On 3/11/26 at 4:30 PM the surveyor observed LPN #23 prepare Resident #2's medications, enter the room, administer the medications and exit the room without hand hygiene.On 3/11/26 at 4:42 PM in an interview, LPN #23 acknowledged that she had not performed proper hand hygiene nor donned PPE for residents on EBP.On 3/12/26 at 8:39 AM the surveyor observed LPN #25 prepare Resident #33's medications, enter the room and administer the medications without hand hygiene. In an interview, she stated, I didn't know to wash before entering.