STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegany Health Nursing and Rehab	730 Furnace Street Cumberland, MD 21502

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and medical record review it was determined that the facility failed to ensure an interdisciplinary care plan meeting was held to review and revise the resident's care plan after the completion of a Minimum Data Set (MDS) assessment. This was found to be evident for one (Resident #6) out of two resident's reviewed for urinary catheter use.The findings include: Care Conferences, also known as care plan meetings, are interdisciplinary team meetings that are to occur following the completion of Minimum Data Set (MDS) assessments. The MDS is a complete assessment of the Resident that provides the facility with the information needed to develop a care plan, deliver the appropriate care and services, and modify the care plan based on the Resident's status. On 3/31/26 at 2:19 PM social worker (SW) #6 was interviewed in regard to the process for scheduling care plan meetings. SW #6 reported that the MDS nurses send out a schedule and that social work usually schedules the meeting 14 days after the assessment date. She went on to report that there is documentation of these meetings in the electronic health record. On 4/1/26 at 10:31 AM review of Resident #6's medical record revealed a MDS, with an assessment reference date of 1/9/26. On 4/1/26 further medical record review revealed documentation that a care conference had occurred on 10/15/25, but failed to reveal documentation to indicate a care conference had occurred after the 1/9/26 assessment was completed. On 4/1/26 at 11:51 AM SW #6 was asked if there was documentation to indicate that a care conference had occurred since October 2025. At 12:32 PM SW #6 and the Nursing Home Administrator (NHA) confirmed that there was no care plan meeting since October. The NHA indicated this was due to the resident transitioning from long term care to skilled care. Cross reference to F 690.

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined that the facility failed to develop a care plan to address the resident's needs related to the use of an indwelling urinary catheter and failed to ensure that a resident was assessed for the possible removal of the urinary catheter. This was found to be evident for one (Resident #6) out of two residents reviewed for indwelling urinary catheter usage.The findings include:On 4/1/26 review of Resident #6's medical record revealed the resident has resided at the facility for more than a year and was sent to the hospital in late December 2025. Review of the discharge Minimum Data Set (MDS) assessment for the December discharge to the hospital revealed the resident was frequently incontinent of urine (unable to control their bladder) and did not have an internal or external urinary catheter in place. The resident was re-admitted to the facility from the hospital in early January 2026.An internal urinary catheter is a medical device consisting of a tube that is inserted through the urethra into the bladder to empty urine. A Foley catheter is an indwelling urinary catheter that remains in place after insertion for continuous drainage of urine. The Foley catheter is held in the bladder by a water-filled balloon which prevents it from falling out.The MDS is a complete assessment of the Resident that provides the facility with the information needed to develop a care plan, deliver the appropriate care and services, and modify the care plan based on the Resident's status. Review of the hospital Discharge summary, dated [DATE], revealed that the resident was noted to have urinary retention during the hospitalization and that a Foley catheter was placed by urology. The note also indicated that the catheter would remain in place at discharge and the resident would follow up in the outpatient setting with urology.Review of the facility's policy regarding Catheter - Urinary Catheter, Cleaning and Maintenance revealed it consisted of a reference to Lippincott Nursing Procedures 9th Ed. (a nursing text book), pages 432 - 435. The facility did not have a facility specific policy regarding catheter use or addressing a plan to discontinue catheters when no longer needed. Review of the referenced [NAME] pages did reveal: Inappropriate or unnecessary use of an indwelling urinary catheter can result in catheter-associated urinary tract infection (CAUTI). Complications associated with indwelling urinary catheter use include CAUTI, genitourinary trauma, bladder fistula (an unusual opening between the bladder and another part of the body), bladder stone formation and incontinence.Continued review of the medical record on 4/1/26 revealed the resident had current orders, in place since January 2026, for an indwelling foley catheter and for catheter care to be provided every shift. Review of the progress note, written by primary care provider physician assistant (PA #23) for a visit on 1/3/26, revealed in the history of present illness section: .Foley catheter placed for Urinary retention. Urology had to placed it due to atrophy and difficult placement. [S/he] is to follow with urology outpatient.Review of a progress note, written for a visit completed by primary care physician (PCP #24) on 1/5/26, revealed in a section titled Interval History, which addressed events that had occurred during the recent hospitalization, included: .[S/he] also had a Foley catheter placed with difficulty and to follow with urology.On 4/1/26 at 10:31 AM review of Resident #6's medical record revealed an MDS, with an assessment reference date of 1/9/26. This assessment included documentation that the resident had an indwelling urinary catheter.Review of the care plan, on the morning of 4/1/26, failed to reveal documentation to indicate the presence of a urinary catheter or interventions to address the resident's needs related to catheter use. Further review of the medical record on 4/1/26 failed to reveal an order for a urology appointment or documentation to indicate the resident was seen by a urologist since the re-admission in January. No documentation was found to indicate there was an attempt to discontinue the use of the indwelling urinary catheter since the resident's re-admission.Review of a progress note written by primary care provider nurse practitioner (NP #25) for a visit on 3/2/26 revealed the resident was seen that day due to a report by nursing of hematuria (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(blood in the urine). The note revealed an indwelling Foley catheter was in place and some bloody urine was observed in the tubing.On 3/2/26 there was an order to flush the foley catheter with 60 cc sterile water every 6 hours for 24 hours. On 3/3/26 there was an order for an antibiotic to be administered twice a day until 3/10/26 for cystitis with hematuria. Cystitis is inflammation of the bladder due to an infection.Further review of the resident's care plans, on the morning of 4/1/26, revealed a plan for occasional bladder and bowel incontinence, which was last reviewed/revised on 3/11/26 by Registered Nurse #21. The 3/11/26 update failed to address the use of the indwelling urinary catheter or that the resident had recently been treated with an antibiotic for a possible urinary tract infection and blood in the urine. On 4/01/26 at 12:34 PM the Director of Nursing (DON) was interviewed about the process when a resident returns from a hospitalization with an indwelling urinary catheter still in place. The DON reported that they look to see if the resident was seen by urology while in the hospital, if there is an appropriate diagnosis for the use of the catheter, and any follow up to see if it should be removed. The DON also reported that they are able to complete bladder scans at the facility.After removal of an indwelling urinary catheter there are often orders to complete a bladder scan after the resident voids to assess if the resident is continuing to retain significant amounts of urine.Further review of the current order for the indwelling foley catheter revealed it was for Obstructive and reflux uropathy, unspecified. Obstructive uropathy is a blockage that makes it difficult or impossible to urinate. However, further review of the January hospital discharge summary and the primary care provider progress notes for 1/3/26, 1/5/26 and 3/2/26 failed to reveal documentation of a diagnosis of obstructive uropathy.During the 4/1/26 interview with the DON the surveyor reviewed the concern that there was no documentation found to indicate there was an attempt to remove the catheter after the January re-admission or that the continued use of the catheter was addressed in the care plan.On 4/02/26 at 8:40 AM, after reviewing the section of the hospital discharge summary that addressed the need for urology follow-up with the surveyor, the DON reported that the resident does have an appointment with urology in May. The DON also reported that the resident has had an indwelling urinary catheter in the past that was removed.On 4/02/26 at 8:50 AM the Appointment Coordinator (#22) reported that the appointment with the urologist was just scheduled the day before. She went on to report that it appears it was missed during the resident's re-admission by nursing.On 4/2/26 at 10:34 AM surveyor reviewed the concern with the corporate nurse (#26) that in addition to the hospital discharge summary, the primary care notes from January 2026 also indicated the need for follow up with urology.On 4/2/26 continued review of the medical record revealed that a care plan to address indwelling catheter use was initiated on 4/1/26. Registered Nurse #18 documented that this plan was reviewed/revised on 4/1/26 at 2:31 PM.