

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215231	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2025
NAME OF PROVIDER OR SUPPLIER Clinton Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9211 Stuart Lane Clinton, MD 20735	

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 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observation, review of survey results binders, and interview, the facility failed to 1) have readily accessible the survey results and 2) have the results from the last survey available for review. This was found on entry into the building and of 1 of 2 survey result binders. The findings include: 1) On 10/28/25 at 8:13 AM, the surveyor requested to review the survey results from the last survey from the front desk receptionist Staff #22. Staff #22 stated that the survey binder was normally kept at the front desk but she was not able to find the book. On 10/28/25 at 8:17 AM, the Director of Nursing (DON) brought the surveyor the surveyor result binder. The DON explained that the Regional Director of Clinical Operations was reviewing the book yesterday and did not return the book to its normal location behind the front reception desk. 2) On 10/28/25 at 8:18 AM, the surveyor reviewed the survey results binder. The results from the survey that was completed in December of 2024 were in the binder; however, the results from the survey completed in June of 2025 were not. On 10/28/25 at 8:42 AM, the DON confirmed that a survey was completed in June of 2025. He stated that the facility had an additional binder on the one [NAME] unit and he would see if that binder had the most recent results. On 10/28/25 at 9:09 AM, the surveyor reviewed the binder from one West. The review revealed that the surveyor results from June 2025 were in the binder. The DON confirmed that he would update the front lobby survey results binder and that the binder was returned to the front for accessibility.</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
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on a review of survey results binders, and interviews, it was determined that the facility failed to protect the privacy of residents' information. This was found evident in 2 of 2 survey results binders. The findings included: On 10/28/25 at 8:17 AM, the Director of Nursing (DON) brought the surveyor the survey results binder that belonged in the front lobby. On 10/28/25 at 8:33 AM, the surveyor reviewed the survey results binder. The review revealed nine pages of residents' names along with their attending physicians, totaling 232 residents' names and physicians' names. On 10/28/25 at 8:42 AM, the surveyor interviewed the Director of Nursing (DON). During the interview, the DON confirmed that the list of residents and their physicians should not have been in the book because the survey results binders are available for anyone to review. The DON stated he had an additional survey results binder on one West. On 10/28/25 at 9:09 AM, the surveyor reviewed the binder from one West. The review revealed that the same nine pages with 232 residents' names along with their physicians were located in this survey results binder as well. On 10/28/25 at 9:18 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview, the NHA confirmed that that list of residents and their physicians would be removed from both survey results binders. He confirmed that they should not have been placed there in the first place.</p>

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>(continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interviews, the facility failed to have an appropriate reason to involuntarily discharge a resident and failed to permit that resident to remain in the facility, and not discharge, while the appeal for discharge was pending. This was found evident in 1 (Resident #21) out of 1 Residents reviewed for involuntary discharges. The findings included: On 11/3/25 at 8:54 AM, the surveyor reviewed intake #2657616 that was submitted to the Office of Health Care Quality (OHCQ). The intake alleged that the facility inappropriately discharged Resident #21. It further stated that Resident #21 had an appeal for his/her discharge and the reason for discharge (non-payment) was inaccurate. It further stated that the facility was aware an appeal was filed and an email had been sent to the social worker to inform the facility. On 11/3/25 at 10:54 AM, the surveyor requested Resident #21's appeal for involuntary discharge from the Director of Nursing (DON). On 11/3/25 at 11:15 AM, the surveyor reviewed Resident #21's discharge summary and noted that Resident #21 was discharged from the facility on 10/23/25 accompanied by his/her parent with plans to go to a relative's home. On further review, a discharge note was written on 10/23/24 at 2:14 PM documenting these same plans. On 11/3/25 at 12:12 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview, the DON presented the notice given to Resident #21 titled: RE: Notice of Proposed Involuntary Discharge or Transfer. The notice was dated 9/22/25 and indicated that Resident #21's proposed discharge date, for home, was 10/23/25. The reason given was: You have failed, after reasonable and appropriate notice, to pay (or to have paid under Medicare or Medicaid) for a stay at this facility. The DON stated he was unaware of an appeal and after talking to the Business Office Manager (BOM) believed that Resident #21 did not have an outstanding bill with the facility. On 11/03/25 at 12:22 PM, the surveyor conducted an interview with BOM #6. During the interview, BOM #6 stated that she prepared the involuntary discharge letter for the previous Nursing Home Administrator (NHA). She stated that she had been monitoring and advising Resident #21 that he/she was close to going over the 18 Leave of Absences (LOA)s days. This being the threshold Medicaid allows while in Long Term Care. The BOM confirmed that Resident #21 did not have a current outstanding bill for his/her stay and that Resident #21 was discharged because Medicaid would not be paying for his/her stay due to going over the 18 LOAs. BOM#6 stated she had been out of the office around 10/23/25 and returned on 10/29/25. She further stated she had not seen the an appeal to the involuntary discharge come through the business office for Resident #21. On 11/03/25 at 12:56 PM, the surveyor interviewed Director of Social Service # 5. DSS #5 stated that she had helped Resident #21 with the discharge and was not aware of any appeal that was filed to contest the discharge. On 11/4/25 at 8:23 AM, the surveyor conducted an interview with Resident #21. During the interview, Resident #21 stated he/she had filed an appeal with the help of the Ombudsman. Resident #21 stated he/she had to stay at a relative's house because his/her residence had a fire and was not able to be occupied at the time of discharge. He/she stated that he/she informed the facility he/she was not ready to leave. On 11/4/25 at 11:38 AM, the surveyor reviewed the appeals letter sent to the Office of Administrative Hearings. The letter was dated 10/17/25 but the email was sent to the office on 10/21/25. The surveyor noted that the letter was also addressed to the facility's previous NHA, the Resident and the Ombudsman. Next, the surveyor asked SSD #6 to provide any recent emails the Ombudsman had sent her. On 11/4/25 at 11:45 AM, the surveyor conducted an interview with the SSD #6. During the interview, SSD #6 brought email correspondence from the Ombudsman dated 10/21/25 at 3:10 PM. In the email the Ombudsman requested a face sheet and inquired about wheelchair repairs, she then wrote: Also, (Resident #21) has filed an appeal to the notice of Involuntary Discharge. SSD#6 responded to the requests in the email on 10/23/25 at 10:06 AM. This was prior to Resident #21's discharge. The surveyor asked SSD#6 how she communicated this information about Resident #21's appeal to the administration. She stated it was discussed during Daily Department Stand Up meetings but could not remember what day or if it was with the old NHA or the current one. The surveyor requested notes taken during the meeting from 10/21/25-10/23/25. On review of the meeting notes on 10/23/25, the Business Office section had noted, one discharge appealed. In the Social work section, it was noted, One appeal for 30 day discharge. On 11/4/25 at 1:21 PM, the surveyor interviewed the Assistant Nursing Home Administrator (ANHA) #20. During the interview, the surveyor relayed the concern that the facility was aware Resident #21 appealed his/her involuntary discharge and that the Resident was still discharged from the facility, as well as the concern that the rationale for involuntary discharge was not valid. Resident #21 did not have an outstanding bill. At the time of exit, no additional information was provided.</p>		