STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215231	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Waters Rehabilitation and Wellness Center	9211 Stuart Lane Clinton, MD 20735

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on resident record reviews, staff interviews, and facility record reviews, it was determined that the facility failed to adhere to professional standards of quality of established clinical practices, physician orders, or facility policies regarding medication administration. This was evident for 11 residents (Resident # 11, #17, #3, #62, #119, #232, #76, #9, #57, #50, and #8) out of 28 residents reviewed for medications during the annual recertification survey. Facilities must ensure that all care and services, including medication administration, adhere to accepted standards of clinical practice. This is often interpreted through established guidelines like the six rights of medication administration: right patient; right medication; right dose; right route; right time; and right documentation. It is a standard of nursing practice to document administered medications immediately after administration. Failing to do this results in an inaccurate record where it cannot be determined when a medication was given and has the potential to result in medication errors (such as a resident receiving a dose twice, or two doses of a medication being given too close in time). The surveyors reviewed resident medication administration records (MARs) and the medication administration audit report for the following residents: 1. On 12/11/2025 at 8:46 AM, the surveyor reviewed Resident # 11's medical records. The resident record review revealed that Resident #11's Medication Admin Audit Report indicated that the resident received the following morning medications late on 12/5/25: Aspirin Oral Tablet Chewable 81 MG, for cerebrovascular accident prophylaxis, was scheduled for 7:00 AM, administered at 2:03 PM, and documented at 2:04 PM; Metformin HCl Oral Tablet 1000 MG, for diabetes mellitus, was scheduled for 7:00 AM, administered at 2:03 PM, and documented at 2:04 PM; Jardiance Oral Tablet 10 MG (Empagliflozin), for diabetes, was scheduled for 7:00 AM, administered at 2:03 PM, and documented at 2:04 PM; Duloxetine HCl 20 MG Capsule delayed release particles was scheduled for 7:00 AM, administered at 2:03 PM, and documented at 2:04 PM; Tramadol HCl Oral Tablet 50 MG (Tramadol HCl), for inguinal pain, was scheduled for 7:00 AM, administered at 2:03 PM, and documented at 2:04 PM; Baclofen Oral Tablet 10 MG, for muscle spasm, was scheduled for 7:00 AM, administered at 2:03 PM, and documented at 2:04 PM; Carvedilol Oral Tablet 12.5 MG, for hypertension, was scheduled for 7:00 AM, administered at 2:04 PM, and documented at 2:04 PM; Gabapentin Oral Capsule 100 MG, for neuropathic pain, was scheduled for 7:00 AM, administered at 2:03 PM, and documented at 2:04 PM; and Sinemet Oral Tablet 25-100 MG (Carbidopa-Levodopa), for Parkinson, was scheduled for 10:00 AM, administered at 1:56 PM, and documented at 2:04 PM. 2. On 12/11/2025 at 9:38 AM, the surveyor reviewed Resident # 17's medical records. The resident record review revealed that Resident #17's Medication Admin Audit Report indicated that the resident received the following morning medications late on 12/5/25: Amlodipine Besylate Oral Tablet 10 MG, for hypertension, was scheduled for 7:00 AM, administered at 2:29 PM, and documented at 2:29 PM; (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aspirin Oral Tablet Chewable 81 MG, for atrial fibrillation, was scheduled for 7:00 AM, administered at 2:29 PM, and documented at 2:29 PM; Jardiance Oral Tablet 10 MG (Empagliflozin) was scheduled for 7:00 AM, administered at 2:29 PM, and documented at 2:29 PM; Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP, for bowel regimen, was scheduled for 7:00 AM, administered at 2:29 PM, and documented at 2:29 PM; Chlorhexidine Gluconate Mouth/Throat Solution 0.12 %, was scheduled for 7:00 AM, administered at 2:29 PM, and documented at 2:29 PM; Metformin HCl Oral Tablet 500 MG, for A1c of 8.0, was scheduled for 7:00 AM, administered at 2:29 PM, and documented at 2:29 PM; Lisinopril Oral Tablet 20 MG, for hypertension, was scheduled for 7:00 AM, administered at 2:28 PM, and documented at 2:29 PM; and Metoprolol Tartrate Oral Tablet 50 MG, for hypertension, was scheduled for 7:00 AM, administered at 2:28 PM, and documented at 2:29 PM. 3. On 12/11/2025 at 9:52 AM, the surveyor reviewed Resident # 3's medical records. The resident record review revealed that Resident #3's Medication Admin Audit Report indicated that the resident received the following morning medications late on 12/5/25: Aripiprazole Tablet 5 MG, for psychosis, was scheduled for 7:00 AM, administered at 12:47 PM, and documented at 12:49 PM; Acetaminophen Tablet 325 MG, for pain, was scheduled for 7:00 AM, administered at 12:46 PM, and documented at 12:49 PM; Artificial Tears Ophthalmic Solution 0.2-0.2-1 %, for dry eyes, was scheduled for 9:00 AM, administered at 12:46 PM, and documented at 12:49 PM; and Aspirin Oral Tablet Chewable 81 MG, for peripheral artery disease and cerebrovascular accident prophylaxis, was scheduled for 9:00 AM, administered at 12:46 PM, and documented at 12:49 PM. 4. On 12/08/2025 at 10:30 AM, the surveyor reviewed the medication administration audit report via the electronic medical record. Resident # 62 on 11/27/25 was scheduled to receive Carvedilol Oral tablets at 1700; the documentation reflects that staff #31 documented and signed the MAR at 19:35 PM. Resident #62 on 12/03/25 was scheduled to receive Carvedilol Oral tablets at 1700. The documentation reflected by staff # 10 was an administration time of 19:24 and a documentation time of 19:35. Resident #62 on 12/03/2025 was scheduled to receive Eliquis 5mg two times per day for DVT, due at 1700, administration time of 19:23 and a documentation time was 19:30. 5. On 12/08/2025 at 10:30 AM, the surveyor reviewed the medication administration audit report via the electronic medical record. Resident #119 on 11/27/25 was scheduled to receive Levetiracetam Oral tablet 500mg, 1 tablet at 17:00, the administration time reflected, and the documentation time were 19:35. 6. Review of the medication administration audit report revealed Resident # 232 was scheduled on 11/27/25 to receive Carvedilol Oral tablet, 625 mg two times a day for hypertension, take one tablet by mouth two time daily with meals, the scheduled time was 17:00, the documented administration time was 19:57 and the documented time by staff #30 was 19:57. The surveyor reviewed the MAR audit report for 12/03/25. Resident # 232 was scheduled to receive Carvedilol Oral tablet, 625 mg two times a day for hypertension, take one tablet by mouth two times daily with meals. The scheduled time was 17:00, the administration time documented was 19:44, and the documentation time was 19:45. The surveyor reviewed the documented administrative times for medications provided to the residents on the 1 [NAME] clinical unit for a seven day period. 7. On 12/8/2025 at 8:01 AM during the Medication Administration facility task for resident #76 with LPN staff #8, this Surveyor observed staff #8 prepare the following six medications: Plavix 75mg, 1 (continued on next page)

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	215231	A. Building B. Wing	12/12/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tab; Amlodipine 10mg, 1 tab; Sertraline 25mg, 2 tabs for a dose of 50mg; Levetiracetam 750mg, 1 tab; MultiVitamin, 1 tab; and Cholecalciferol 0.1mg, 1 tab; for a total of 7 tabs that this Surveyor observed placed in the medication cup. While still at the medication cart, this Surveyor then asked LPN staff #8 how many pills they had placed in the cup; staff #8 stated '7', thus confirming the number of tabs pulled for this administration. LPN staff #8 proceeded to resident #76's bedside, administered the medications, returned to the medication cart, and began to chart the medications given. This Surveyor observed staff #8 select the 6 medications above and then selected 'Aspirin 81mg, 1 tab', and marked them all as given, despite not preparing the Aspirin medication along with the other medications. This Surveyor shared with the LPN staff #8 that only the 6 medications above were pulled, placed in the medication cup, and then confirmed with the staff member before going to the bedside for administration. This Surveyor then asked the LPN staff #8 again, how many pills were stated before administration, again, staff #8 stated '7'. LPN staff then stated, I did give it, removed the Aspirin bottle from the standard medication drawer. This surveyor did not observe staff #8 preparing the Aspirin during the initial setup of the medications. 8. On 12/8/2025 at 8:15 AM during Medication Administration facility task for Resident #9 with LPN staff #8, this Surveyor observed staff #8 prepare the following three medications: Acetaminophen 325mg, 2 tabs for dose of 650mg; Ascorbic Acid 500mg, 1 tab; the medications were crushed, placed in a medication cup and then approximately 5mL of Liquicell (liquid modular protein) was poured from a large multi-use bottle on top of the medication cart, added to the medication cup and mixed with the crushed powder. Then, Oxycodone Hydrochloride 5 MG/5 ML Oral Solution was added to another medication cup; the medication was not signed out of the Narcotic Count book before preparation. Before entering the resident room, this Surveyor asked was the Liquicell that was used to mix the crushed medications was considered a medication; LPN staff #8 stated 'Yes'. When asked if this resident was ordered for this medication, staff #8 stated, 'We use it to mix the medications and give it to the residents.' Staff #8 then proceeded to resident bedside, administered the medications by spooning the medications into the resident's mouth, exited the resident's room, returned to the medication cart and began charting the medications given. Staff #8 selected 'Acetaminophen Rectal Suppository 650 MG' as given despite giving oral Acetaminophen to the resident. The Surveyor then observed staff #8 proceeded to prepare for the next resident; however, this Surveyor intervened and asked at what point the narcotic was given to Resident #9 would be signed out of the Narcotic Book; staff #8 stated, the resident sometimes may not take the medication'. Staff #8 then obtained the book and signed the medication entry after the medication administration was completed. When asked if the medication protocol is to sign out the narcotic first and then what to do if the resident refused, staff #8 stated, the medication should be signed out first, and if not taken, discarded with 2 nurse staff members'. Additionally, during record review for Resident #9, the following medications were due and omitted during this administration: Modular Protein, 30 mL with 120 mL water/beverage (Liquicell is the facility substitute); and Zinc Sulfate 220 MG, 1 Capsule. 9. On 12/8/2025 at 8:38 AM during the Medication Administration facility task for Resident #57 with LPN staff #5, this Surveyor observed staff #5 prepare the following medications: Donepezil hydrochloride 10MG, 1 Tablet; Cholecalciferol 0.025MG, 1 Tablet; empagliflozin 25MG (Jardiance), 1 Tablet; Magnesium Oxide 400MG, 1 Tablet; Metformin Hydrochloride 500MG, 1 Tablet; Vitamin B12 1 MG, 1 Tablet; a total of 6 medications. Staff #5 went to the bedside, administered the medications, and returned to the medication cart to chart the medications as given. During this time, staff #5 selected the 6 medications, and in addition selected 'Fluticasone-Salmeterol 100-50 MCG/ACT Aerosol Powder, breath activated' and then marked all of them as given despite not actually giving the resident the inhaler. At this time, staff #5 stated, 'Oh, I missed the inhaler, and I needed a fingerstick.'; LPN staff #5 then asked LPN/MDS Coordinator staff #8, who was also present at the medication cart, (continued on next page)

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	215231	A. Building B. Wing	12/12/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to obtain a fingerstick. This Surveyor then observed staff #8 offer to administer the inhaler, staff #5 gave the inhaler to staff #8; staff #8 then went to the bedside to administer the medication, returned to the medication cart, and stated 'I got the fingerstick, it is 119, and I gave the inhaler'. This surveyor asked LPN staff #5 what the expectation is on charting on medications not given and then giving the medication to someone else to administer, staff #5 stated, this nurse was sent to help today, they are not new, they are a nurse too'. Additionally, during record review for resident #57, 'Dulaglutide Subcutaneous Solution Auto-injector 1.5MG/0.5ML (Dulaglutide) Inject 1.5 mg subcutaneously was due at 8:00 AM'; it was given late, and this was after the resident consumed their meal and a late fingerstick that was performed. On 12/8/2025 at 9:39 AM, during staff interviews with the Regional Director of Process Improvement, staff #14, DON staff #2, and NHA staff #1, this Surveyor shared the above findings that were observed during the medication administration facility task. When asked about the expectation for signing out narcotics, late medications, charting on medications not given, and charting medications but allowing other staff members to administer the medication, DON staff #2 stated, 'These behaviors are not our policies or expectations for safe medication administration.' 10. On 12/8/25 at 8:47 AM, during review of the medication administration audit report for Residents #50 and Resident #8, it was noted that several medications were documented as late delivery to the residents. Resident #50 had the following medications on 12/5/25 that were late: Lantus insulin was due at 7 AM, administered at 1:08 PM, and documented at 3:08 PM. Compression stockings were due at 9 am and were administered at 4:12 PM. Flasp insulin was due at 4:30 PM and was administered at 11:09 PM. Baclofen due at 5 PM, administered at 11:09 PM; Metformin due at 5 PM, administered at 9:39 PM; and Compression stockings due at 9 PM, administered at 11:15 PM. 11. Resident #8 had the following medications on 12/5/25: Amlodipine, Folic Acid, Cyanocobalamin, Nephro-Vite, and Quetiapine were due at 7 AM, and all of them were signed off at 11:08 AM. On 12/8/2025 at 9:01 AM, the surveyors interviewed the Director of Nursing, staff #2. During the interview, the surveyor asked staff #2 what the expectations of staff are when administering medication to residents. Staff #2 stated that the expectation is that staff sign and document medication administration immediately after administering medication to the resident. On 12/8/2025 at 1:30 PM, the surveyors reviewed the facility's Medications Administration policy and procedure. The facility's Medications Administration policy and procedure stated that medications will be charted when given and medications will be administered within the time frame of one hour before up to one hour after time ordered.

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	215231	A. Building B. Wing	12/12/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, it was determined that the facility failed to maintain the resident right to a dignified existence, by leaving visibly soiled linens on the resident's bedside during their meal while at bedside. This was evident for 1 (resident #122) out of 1 resident observed for Resident Rights during the annual survey.Findings include:On 12/4/2025 at 8:24 AM during initial observation rounds of resident #122, there were visibly soiled linens-a sheet and washcloth, with brown stains and a strong odor of stool noted, partially rolled up and positioned toward the end of the bed. The resident, a bilateral above-the-knee amputee, was observed sitting in a wheelchair at bedside, with the bedside table partially across the bed. When asked about the linens left at the end of the bed, the resident stated, ?I clean myself every morning and leave the linens there for staff to collect it'. Surveyor asked the resident did they asked a staff member this morning to remove the soiled linens; the resident stated, 'the linens were there when the aide came to get my breakfast tray, and I do this every morning'. The resident was then asked at what time the linens get removed, the resident stated, ?it's moved usually around 9a or 10a'.On 12/4/2025 at 9:39 AM during an interview with DON staff #2 and NHA staff #3, this Surveyor shared the findings of soiled linens left at bedside in a resident room and the resident stating they cleaned themselves daily and the linens remain there even after the meal tray is removed by staff. The Surveyor asked was this the expectation to leave visibly soiled linens at bedside, even if tray distribution or pickup is in progress; DON staff #2 stated ?No'.

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	215231	A. Building B. Wing	12/12/2025

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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, record reviews and staff interviews, it was determined that the facility failed to ensure residents are not in public view and to provide a privacy curtain to prevent exposure of resident body parts. This was evident for 1 (resident #10) out of 1 observed without a privacy curtain between bed A and bed B in a 3-bed room during the annual survey.Findings include:On 12/04/2025 at 7:50 AM during initial observation rounds, this Surveyor observed resident #10 lying in the middle bed (Bed B) of the room, that was occupied by 3 residents. During this observation, resident #10 (Bed B) was positioned parallel to Bed C bed to the right closest to the window, while Bed A bed was positioned perpendicularly to the left and closest to the door. There was no privacy curtain observed between resident #10 (Bed B) and the resident occupying Bed A.On 12/04/2025 at 12:00 PM during an interview with NHA staff #3 and DON staff #2, this Surveyor notified the team of the findings. When asked what the expectation for privacy curtains in the 3-occupant rooms was, DON staff #2 stated, ?the expectation is for a privacy curtain to be present between each resident'.On 12/05/2025 at 11:28 AM during follow-up observation rounds, a privacy curtain was observed between resident #10 in Bed B and Bed A; this was completed after surveyor intervention.

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	215231	A. Building B. Wing	12/12/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, it was determined that the facility failed to ensure the safety of the resident room environment by not limiting the presence of potential hazards. This was evident for 5 (rooms 227, 229, 234, 235, and 237) of 26 resident rooms observed during the annual survey.Findings include:On 12/4/2025 at 7:57 AM during initial observation rounds wall-mounted thermostats were observed without outer protective covers with the internal elements exposed in rooms 234 & 237. Additionally, in rooms [ROOM NUMBER], resident dressers were observed with broken/missing doors compartments. On 12/4/2025 at 9:30 AM during the entrance conference with NHA staff #3 and DON staff #2, findings shared about thermostats that were observed without outer protective covers and broken dresser doors that were observed in the resident rooms.On 12/12/2025 at 9:23 AM during follow-up observation rounds, the thermostats without protective coverings and internal elements and the broken/missing dresser doors were again observed.On 12/12/2025 at 9:55 AM during follow-up interview with DON staff #2, this Surveyor updated facility on the follow-up observations; staff #2 stated ?the plan is to provide temporary covers to the exposed thermostats within the resident rooms and replace the dressers'.

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	215231	A. Building B. Wing	12/12/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews and staff interviews, it was determined that the facility failed to ensure medications were administered in accordance with physician orders for 6 of 26 opportunities reviewed. This deficient practice resulted in residents receiving medications contrary to physician orders and a medication error rate of 23.08%.Findings include: 1. On 12/8/2025 at 8:01 AM during the Medication Administration facility task for resident #76 with LPN staff #8, this Surveyor observed staff #8 prepare six medications for a total of 7 tabs that this Surveyor observed placed in the medication cup. While still at the medication cart, this Surveyor then asked LPN staff #8 how many pills they had placed in the cup; staff #8 stated ?7', thus confirming the number of tabs pulled for this administration. LPN staff #8 proceeded to resident #76's bedside, administered the medications, returned to the medication cart, and began to chart the medications given, however one error was observed. ?Aspirin 81mg, 1 tab' was selected and charted as given, despite not preparing or giving the Aspirin medication along with the other medications. This Surveyor shared with the LPN staff #8 that the Aspirin was never pulled with the original 6 medications (for 7 tabs) that were placed in the medication cup and confirmed with the staff member prior to going to the bedside for administration. This Surveyor then asked the LPN staff #8 again how many pills were stated prior to administration, again staff #8 repeated ?7'. LPN staff #8 then stated, ?I did give it', at which point staff #8 then removed an Aspirin bottle from the standard medication drawer. This Surveyor did not observe staff #8 preparing the Aspirin during the initial set-up of the medications. 2. On 12/8/2025 at 8:15 AM during Medication Administration facility task for resident #9 with LPN staff #8, three errors were observed. First, Acetaminophen 325mg, 2 tabs for dose of 650mg was crushed and given orally, however was charted as given as a suppository rectally, the wrong route. Second, Zinc sulfate 220MG, 1 Capsule was omitted. Third, despite staff #8 using Liquacell (Modular Protein) 5mL to mix with the crushed oral medications, per physician orders resident #9 was written for ?Modular Protein, 30 mL w/120 mL water/beverage' also to be given during the morning medications; however, this medication dose as written was omitted.3. On 12/8/2025 at 8:38 AM during the Medication Administration facility task for resident #57 with LPN staff #5, two errors were observed. First, ?Fluticasone-Salmeterol 100-50 MCG/ACT Aerosol Powder, breath activated' was selected and charted as given by LPN staff #5; however, the medication was omitted during the initial medication administration. Second, ?Dulaglutide Subcutaneous Solution Auto-injector 1.5MG/0.5ML (Dulaglutide) Inject 1.5 mg subcutaneously in the morning, at 8AM' was not given per physician orders on time, this medication was charted as given at 9:14 AM, over an hour after it was due.On 12/8/2025 at 9:39 AM during staff interviews with Regional Director of Process Improvement staff #14, DON staff #2, and NHA staff #1, this Surveyor shared with the administrative team these findings observed during medication administration facility task.

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	215231	A. Building B. Wing	12/12/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, it was determined that the facility failed to maintain proper records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and, failed to properly dispose of medications of a discharged resident. This was evident for 2 (residents #119 and #230) out of 2 residents reviewed for medication labeling and storage review during the annual survey.Findings include: 1. On 12/8/2025 at 1:57 PM during medication storage observation rounds with LPN staff #10 of the 1W Medication Cart #2 Narcotic Book-Team 2, it revealed the following entry for page No. 117: Resident #119; Oxycodone 5mg/5mL solution; Date: 11/15/25; Time: 14:00; Amount on Hand: 30mL; Amount Used: 0; Method: 0; and Amount Left: 30mL; however, the medication was not present in the narcotic locked box of Cart #2 as the Narcotic Book-Team 2 indicated. When asked about the location of this medication, staff #10 stated, 'this resident is on the other side of the (1W) unit and this medication was transferred to the other cart (Cart #1)'; however, the narcotic sheet did not reflect this transfer at the bottom of the sheet in the 'MEDICATION TRANSFERRED' section. Staff #10 stated 'I notified the LPN Unit Manager #4 on yesterday' (Sun, 12/7/25). This Surveyor completed a record review of Resident #119's room census with staff #10, which revealed resident #119 was admitted to room [ROOM NUMBER]A on 11/12/25 and then transferred to room [ROOM NUMBER]A on 11/14/25; however, the controlled medication was maintained on Cart #2 Narcotic Book-Team 2. This Surveyor then completed medication storage observation rounds of 1W Medication Cart #1 Narcotic Book-Team 1 with LPN Unit Manager staff # 4, it revealed an entry on page No. 139 for this same resident (resident #119). Page No. 19 revealed: Oxycodone 5mg/5mL solution; Date: 12/5/25; Time: 3p; Amount on Hand: 30mL; Amount Used: (-); Method: (-); and Amount Left: 30mL. The medication was observed in the locked medication box of Cart #1, sealed and unused. The prescription label on the bag revealed: Rx#14490599, NS: 1W, Rm: 112-A, Date: 11/14/25, Dt Wrt: 11/14/25, Res #119, OXYCODONE 5mg/5mL SOLN. When asked why this medication was reflected in two places as an active controlled substance medication that was transferred on 12/5/25, despite the resident room change on 11/14/25; staff #4 stated the medicine was not properly reconciled out of the other Narcotic Book (Team 2) when the medication was moved to this cart (Cart #1)'. On 12/8/25 at 2:28 PM during follow-up observation and interview with DON #2, this Surveyor shared the findings. When asked was the process correctly followed and what the expectation of transferring medications for transferred residents; this Surveyor was told 'the expectation is to transfer the medication at the time the resident is transferred, and to complete the page in the Narcotic book.' 2. On 12/9/2025 at 11:51 AM during observation rounds with Charge RN staff #15 of the 1W Medication Storage Room and Refrigerator this Surveyor observed medications for resident #230; the label appeared old and was fading, it read: Rx# 12578636, Dt Wrt: 02/11/25, [NAME]: 03/05/25, LATANOPROST 0.005% OPTH SOLN; the remaining label was partially ineligible. This Surveyor asked staff #15 was this resident (#230) still a resident at the facility; staff #15 stated No. When asked who reconciles the medication refrigerator for discharged residents; staff #15 stated, I don't know, possibly the manager'. (continued on next page)

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	215231	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Waters Rehabilitation and Wellness Center	9211 Stuart Lane Clinton, MD 20735

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/2025 at 12:40 PM during follow-up observation and interview with DON #2, when asked was this the expectation of reconciling medications of discharged residents from the facility; this Surveyor was told 'No, the expectation is to remove the medications and return them to Pharmacy as per protocol.' 3. On 12/8/25 at 11:00 AM, during a medication storage check of the 3 [NAME] unit, the surveyor observed lacosamide 150 mg tablets in the resident's narcotic box. Review of the Narcotic Count Log revealed 12 tablets remaining, although a dose had been administered. During an interview, Nurse Staff #36 stated she administered the medication but forgot to sign it off. This resulted in an inaccurate narcotic count, compromising medication record integrity and controlled-substance accountability.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure residents received the menu-specified type and required portion size of juice during the breakfast meal service. Specifically, residents on 2 [NAME] unit were provided with less than the required 4 ounces of juice, and at least one resident (#106) received a juice type inconsistent with their dietary order. This failure had the potential to negatively affect 2 west residents' nutritional intake, preferences, and compliance with physician-ordered diets.Findings include:On 12/4/25 at approximately 8:00 AM, during observation of the breakfast meal service on 2 West, the surveyor observed GNA Staff #34 placing clear plastic cups on top of the meal cart and pouring approximately 2 ounces of apple juice into each of approximately 15 cups prior to tray delivery.Review of the facility's posted breakfast menu for that date indicated residents were to receive 4 ounces of juice with breakfast.During continued observation, Resident #106 was observed with two clear plastic cups of apple juice on the breakfast tray. Each cup contained approximately 2 ounces of juice. When interviewed at that time, the resident stated, I don't like apple juice.Review of the dietary slip for Resident #130 revealed the resident was ordered to receive 4 ounces of orange juice with breakfast. There was no documentation to indicate a substitution, refusal, or resident preference change that had been made.During an interview on 12/4/25 at approximately 8:15 AM, GNA Staff # 34 stated, The juice is poured into cups before we serve the trays to make sure there is enough for everyone.During an interview on 12/5/25 at approximately 10:00 AM, the Regional Dietary Manager stated, There is enough juice sent to the units for each resident. We send 6-ounce cups to 2 West, and the nursing staff is to administer 4 ounces of juice as ordered to each resident. When asked if cups were sent to the unit on 12/4/25 during breakfast, the Regional Dietary Manager stated that the cups were not sent in error.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview with residents and facility staff, it was determined that the facility failed to ensure that food was delivered to residents at an appropriate and palatable temperature. This was evident for 1 out of 1 observation of test tray temperatures. This practice has the potential to affect all residents on the 3 [NAME] clinical unit who eat food prepared by the facility. The findings include:On 12/05/2025 9:22 AM Resident #92 stated the food is okay but food items arrive cold such as potatoes and eggs. The temperature testing of the facility lunch meal on 12/11/2025 12:15PM inside the facility kitchen revealed the following: the internal temperatures of the food items to be served to the residents on unit 3 [NAME] did meet the standards of professional practice. However, the subsequent temperature testing of the selected test tray sent to the 3 [NAME] clinical unit did not meet the standard of practice for internal temperatures of the meat and vegetables.On 12/11/2025 at 12:15 PM staff # 33, the regional dietary director performed the temperature testing on the preparation trays held the following food items: regular barbeque pork: 179 degrees, grilled cheese sandwich: 145.9 degrees, tater tots: 140.7 degrees, lima beans: 177 degrees, macaroni noodles: 166.8 degrees, brown gravy: 158 degrees, pureed mashed potatoes: 186 degrees, pureed lima beans: 157.7, shredded pork: 177 degrees. The three portable food carts designated to the 3 [NAME] clinical unit began leaving the facility kitchen at 12:25 PM and the last food cart arrived on the unit at 12:30 PM on 12/11/2025. The test tray was placed on the third food cart.On 12/11/2025 the surveyor at 12:35PM observed that all three portable food carts utilized to deliver the lunch meal to the residents on 3 [NAME] did not possess external doors which prevented the food trays from having additional protection from heat loss while traveling through the facility, the elevator, and while on the clinical unit prior to staff distributing the lunch meal. The surveyor discussed the concern of the portable food carts whose doors had been with staff #33 and he stated that repair orders had been submitted to the facility maintenance director several months ago but no action had been taken at this time. The test tray temperature results for the lunch meal served on unit 3 [NAME] on 12/11/2025 at 12:45 PM were as follows: fruit punch: 40.7 degrees, hot water: 146.7 degrees, peaches: 44.2 degrees, lima beans:124.0 degrees, tater tots: 113 degrees, shredded barbeque pork:120 degrees.The facility failed to maintain a holding temperature above 135 degrees for the lima beans, the tater tots, and the shredded barbeque pork which would directly impact the palatability and preferred temperature of the residents.The results of the test tray temperatures were reviewed with the regional dietary director, staff #33, the administrator, and the DON on 12/11/2025 at 2:15 PM.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews and staff interviews, it was determined that the facility staff failed to maintain medical records for a resident in accordance with accepted professional standards and practices to contain accurate documentation. This was evident for 1 (resident #15) out of 1 resident reviewed for accurate identifiable information during the annual survey.Findings include:On 12/5/2025 at 12:03 PM during observations and interviews, resident #15 complained of wounds and discomfort to their bilateral heels. The resident was observed supine in bed, socks on both feet that were resting directly on the mattress with no pillow or heel-relieving device being used. This Surveyor asked resident #15 if they were instructed to elevate their heels off the bed for some relief; resident #15 stated, No. Resident #15 then offered to show this Surveyor their heel wounds and was able to remove their own socks. This Surveyor observed both heels, which revealed an approximate 3cm x 2cm open area to the Left-heel and a 2cm x 1.5cm open area to the Right-heel. This Surveyor then shared the residents' concerns and findings with LPN staff #6, who was on the unit upon exiting the resident room that day.On 12/11/2025 at 9:00 AM during record review of resident #15, it was revealed that after Surveyor intervention, a wound care assessment and treatment recommendations were completed, per the HP SKIN AND WOUND NOTE, dated 12/8/25 at 21:53. Additionally, resident #15 Care Plan Report reflected interventions for the bilateral heels as well. However, the ?Weekly Skin Check - V3' form, completed by resident #15 primary nurse, LPN staff #7, was answered as follows: Skin Check, 1. Has resident refused skin check? -?No'; 1a. Are there any skin area(s) noted? - ?No'; Signature, 1. Nurse completing this UDA: staff #7; signed by staff #7; Signed Date: 12/8/25. Based on these findings it appeared that, despite resident #15 having wounds to the bilateral heels, the weekly skin sheet completed by the LPN staff #7 on 12/8/2025 did not accurately reflect the resident's current medical condition of wounds to the bilateral heels, as being consistent with the remaining records.On 12/11/2025 at 12:00 PM during an interview with LPN staff #7, when asked what was the Weekly Skin Check - V3' form was used for; staff #7 stated, ?for the weekly skin assessment of the resident'. This Surveyor then asked was a skin assessment required when completing this form; staff #7 stated ?Yes'. The Surveyor then discussed the ?Weekly Skin Check - V3' form completed by staff #7 on 12/8/25 and asked about their reply to the skin check question (1a. Are there any skin area(s) noted?' answered as ?No'; staff #7 stated, I thought it referred to new skin areas, I am aware the resident has heel wounds and I answered incorrectly'.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record reviews and staff interviews, it was determined that the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections based on an established infection prevention and control program. This was evident for 2 (residents #158 and #9) out of 46 residents observed during initial review for Infection Prevention & Control during the annual survey.Findings include:1. On 12/04/2025 at 8:16 AM during initial observation rounds, resident #158 urinary catheter/Foley bag was observed resting on the floor at the resident's bedside.On 12/04/2024 at 12:00 PM during an interview, NHA staff #3 and DON staff #2 were notified of the findings and infection control concerns for observing the resident urinary catheter/Foley bag on the floor next to the resident's bed.On 12/10/2025 at 12:51 PM during record review for resident #158, it revealed physician orders for the resident urinary catheter/Foley, placed 7/11/25 for acute urinary retention and worsening function; resident later diagnosed w/Obstructive Uropathy.On follow-up observations completed on 12/5/2025 at 11:51 AM and 12/12/2025 at 9:18 AM, now after Surveyor intervention, resident #158 urinary catheter/Foley bag was observed hooked to the lower portion of the resident bed, away from the floor.2. On 12/8/2025 at 8:15 AM during the Medication Administration facility task for resident #9 with LPN staff #8, this Surveyor observed staff #8 walk into the resident room with the prepared medications. The resident room had the following sign displayed: ?Enhanced Barrier Precautions', which indicated ?STOP: EVERYONE MUST: Clean their hands, including before entering and when leaving the room'. Staff #8 proceeded to the bedside, spooned the medications into the resident mouth without performing hand hygiene before or after administration or wearing protective gloves during the administration.On 12/8/2025 at 9:39 AM during staff interviews with Regional Director of Process Improvement staff #14, DON staff #2, and NHA staff #1, this Surveyor shared these findings with the administrative team, that were observed during the medication administration facility task.