STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of the facility's abuse policy and interview it was determine that the facility failed to ensure the abuse policy addressed all the required components. This was found to be evident for the one abuse policy and has the potential to affect all the residents.The findings include: This regulation was written to provide protections for the health, welfare and rights of each resident residing in the facility. In order to provide these protections, the facility must develop written policies and procedures to prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property. These written policies must include, but are not limited to, the following components: Screening; Training ; Prevention; Investigation; Protection; and Reporting/response. On 8/26/25 review of the abuse policy, that was provided to the survey team at the start of the survey, failed to reveal a date that it was initiated or reviewed. On 8/26/25 at 10:43 AM the nursing home administrator (NHA) confirmed this was the abuse policy that is provided to staff. The policy included definitions of physical, sexual and verbal abuse, neglect and exploitation and included a list of some physical, behavioral and social signs of abuse. The policy failed to address misappropriation of resident property. The policy failed to address abuse prevention or training of staff. The policy failed to address coordination with the Quality Assurance Performance Improvement program. In regard to reporting abuse the policy stated: In the event that anyone in the facility (employee, visitor, family member, service provider, etc) has evidence or credible cause to believe that a resident has been subject to any or all of the above types of abuse, that person with knowledge is strongly encouraged to report in good faith all allegations, suspicions, or incidents to an administrative staff member, the Ombudsman or to the State officials as posted in the facility. A report may be made either in written or oral form should contain as much information as the reporter is able to provide Allegations of abuse and neglect will be reported to the Administrator within 24 hours of the allegation (8 hours for Washington DC) and initial report to the state agencies will be completed as per regulation. Federal regulation requires that allegations of abuse are reported immediately, but not later than 2 hours after the allegation is made, to the NHA and other officials. Cross reference to F 609. The policy failed to address prohibiting and preventing retaliation for reporting suspected abuse. On 8/26/25 at 1:00 PM observations made throughout the facility, including employee break areas, failed to reveal posted signage of employee rights related to retaliation against the employee for reporting a suspected crime. On 8/26/25 at 1:18 PM the NHA confirmed they do not have this specific signage posted in the facility. On 8/26/25 at 1:18 PM surveyor reviewed the concern with the NHA that the facility's abuse policy does not include all of the components required by the regulation.

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
	215247	A. Building B. Wing	08/29/2025

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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. Based on observations and interviews, it was determined that the facility failed to store food in accordance with professional standards. This deficient practice has the potential to affect all residents.The findings include:1) An initial tour of the facility's kitchen with Staff #23, the dietary director, on 8/19/2025 at 7:30 AM revealed the following in the walk-in refrigerator and walk-in freezer:-Leftover Roast Beef with a date prepared as 3/18/25 and a use-by date of 3/21/25. Staff said that it should have been discarded a long time ago. Staff took it to discard it. - Leftover Tortellini pasta salad with a date prepared as 8/13/25 and had no use-by date. Staff stated it should have been discarded a day prior.-Roasted Turkey with a date prepared as 8/6/25 had no use-by date. Staff stated that it should have been used by 8/9/25.-Leftover diced chicken with a use-by date of 8/12/25, with no date of preparation.-Leftover Ham salad with the date prepared as 8/15/25 and use-by date of 8/18/25.-Leftover Chicken salad dated 8/13/25, the Staff said the date was the use-by date. -Peanut sauce with a date prepared 8/13/25 and had no use-by date.-Cooked rice dated 8/14/25. Staff said that was the date of preparation, and it had no use-by date.-Sweet cream cheese with date prepared 8/13/25 and had no use-by date. -Mixed vegetables with no use-by date. During an interview with Staff #23, he stated that he had already identified the food labeling concerns and initiated a new labeling process. Staff said he had yet to train his Staff about the new process. 2) An observation of the facility's nutrition room refrigerator on 8/20/2025 at 3:20 PM, with Staff #25, a Registered Nurse, showed a carton of Thick and Easy thickened apple juice with a use-by date of 7/3/25. Continued observation noted a carton of Thick & Easy thickened orange juice with a use-by date of 6/4/25. Staff #25 indicated they had expired and discarded them after the surveyor's intervention. In an interview on 8/20/2025 at 3:26 PM, the Director of Nursing reported that the Dietary Staff was responsible for cleaning and discarding expired items from the unit refrigerator.During an interview on 8/21/2025, at 8:17 AM, staff #23 indicated that he had just been made aware that it was the responsibility of the dietary Staff to stock and clean the nutrition room refrigerator, so he had begun educating his Staff about this.

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	215247	A. Building B. Wing	08/29/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews and observations, it was determined that the facility failed to 1) have a water management system in place to identify Legionella and other harmful waterborne germs in the building and 2) ensure that wall-mounted Hand sanitizing dispensers in resident and staff areas were maintained within their expiration dates. This was evident during the recertification survey.The findings include: Legionella is a bacterium that can cause a serious type of pneumonia called Legionnaires' Disease in people at higher risk, such as those over fifty years old, people with chronic lung disease, or those with weakened immune systems. Legionella can grow in areas of a building that stay wet (such as pipes, faucets, storage tanks, and decorative fountains) and can spread through the air in tiny water droplets. 1) On [DATE] at 3:00 PM, the surveyor interviewed the Director of Nursing (DON) and asked who was serving as the Infection Preventionist. The DON stated that the Assistant Director of Nursing (ADON) had recently left the facility and that she (the DON) was currently filling the role until the new ADON was trained. On [DATE] at 10:00 AM, the surveyor again interviewed the DON and asked who was responsible for managing water risks in the facility. The DON stated that it was likely the Environmental Services Director (ESD). On [DATE] at 4:00 PM, the surveyor reviewed the Facility Risk Assessment and found a section that included test results from Fountain Valley Analytical Lab for Legionella bacteria. The water samples were collected on [DATE] and [DATE]. All results were negative. On [DATE] at 10:18 AM, the surveyor interviewed the Nursing Home Administrator (NHA) and asked to see the facility's water management plan and how testing locations for Legionella were determined. The NHA stated that she would reach out to the ESD to see if he had information about an assessment but believed that Fountain Valley had conducted a risk assessment. On [DATE] at 10:30 AM, with the surveyor present, the NHA called the ESD and asked if an assessment had been completed. The ESD stated that he had not conducted a risk assessment or created a water management system but thought Fountain Valley may have performed one since they do the testing. Shortly after, the ESD called the NHA back and confirmed that no type of assessment had been completed. On [DATE] at 1:10 PM, the surveyor spoke with the NHA and ESD. They stated, we found a Legionella toolkit and are working on an assessment. The surveyor asked if they were aware that regulations require a water management plan to address waterborne germs. The NHA responded, we do now. On [DATE] at 1:18 PM, the surveyor again spoke with the NHA and asked for clarification: Did you have a Legionella risk assessment or water plan for the facility in the past? The NHA responded, No, we didn't, but are working on one now. 2) During a tour of the facility on [DATE], at 1:25 PM, with the Director of Nursing (DON) present, an (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observation was made of ten wall-mounted Hand sanitizing dispensers in both units of the facility, which had expiration dates of February 2024. The DON confirmed that they were all expired and removed them for disposal. The DON also stated that she would notify the Environmental Services Director, staff #2, immediately. In an interview on [DATE], at 11:35 AM, Staff #2 reported that the wall-mounted Hand sanitizing dispensers were replaced when they were low or expired. However, earlier observations failed to show that ten expired ones were replaced. Staff #2 stated that he was already made aware of the concerns and had taken care of them after the surveyor's intervention.

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	215247	A. Building B. Wing	08/29/2025

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to report allegations of abuse in a timely manner. This was evident for 5 (#80, #81, #77, #10, and #71) of 15 residents reviewed for abuse allegations.The findings include:1) Resident #80 has medical diagnoses of hydrocephalus (fluid build-up in the brain) with a shunt (a device that drains the excess fluid), chronic kidney disease, nutritional deficiencies, hypertension, and is in palliative care (medical care focused on quality of life for individuals with life-limiting illnesses). On 8/28/25 at 3:00 PM, the surveyor reviewed a Facility Reported Incident (FRI) #337730, which stated the following: Resident #80 and the Director of Nursing (DON) met on 7/24/24 after receiving an allegation from the resident’s family member. According to the resident: “I have terrible veins and a tough stick. A gentleman drew my blood last week (Monday or Tuesday) and I told him where to stick me, but he didn't listen. He looked at my left arm, which I told him was useless, then he looked at my right arm. I have done blood draws in the past, so I know what I am talking about. He put the tourniquet here (pointing to the right forearm) so tight causing my skin to pucker. He stuck me five or six times (pointing to three locations on the right arm: top of the forearm, top of the hand, and wrist). He did get blood once but removed the needle and stuck me somewhere else. I guess it was just flash. When he stuck my wrist, he grabbed my hand and squeezed it so tight. I asked him to stop but he squeezed it again. After that I told him to stop and leave the room. He never got my blood that day.” Facility documentation states that the DON was first notified of this incident via voicemail from Resident #80’s family member on 7/24/24 at 9:00 AM. The Nursing Home Administrator (NHA) reported the incident to the Office of Healthcare Quality (OHCQ) on 7/26/24 at 3:30 PM. On 8/29/25 at 8:48 AM, the surveyor reviewed [NAME] Hill’s policy and procedure titled “Resident Abuse Policy and Procedure” (no date or policy number), which in part states: · “Allegations of abuse and neglect will be reported to the Administrator within 24 hours of the allegation and initial report to the state agencies will be completed as per regulations.” On 8/28/25 at 4:02 PM, the surveyor spoke with the facility Nursing Home Administrator (NHA) and asked if she was aware of the reporting requirements for allegations of abuse. She stated that she “must report within two hours.” The surveyor then asked her to review the internal investigation documentation regarding Resident #80’s allegation of abuse, and she acknowledged that the facility reported the allegation late. 2)Review of Resident #81's medical record revealed the resident was admitted to the facility in June 2024 after a brief hospitalization. Review of the Minimum Data Set (MDS- a required standardized assessment) with an assessment reference date of 7/3/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Review of facility reported incident #337729 revealed that it was a report of an allegation of misappropriation of resident property/exploitation. (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the statements included in the facility investigation revealed a statement, signed by Receptionist #22 which revealed that on 7/11/24 the resident had told her: .someone on night shift 2 days prior had stolen $50 dollar bill out of [his/her] [bag].” On 8/29/2025 at 9:28 AM Receptionist #22 read the statement and confirmed it was accurate and that it was her signature on the statement. Further review of the statements revealed two statements, dated and signed by the Director of Nursing (DON) on 7/11/24. The first of these two statements revealed the DON had received a message from Receptionist #22 that Resident #81 had stated that a $50 bill was stolen and that the DON had conducted an interview with the resident on 7/11/24. This statement also indicated that the resident reported s/he always kept a $50 bill folded in [his/her] [bag] for emergencies. The second statement revealed the DON had interviewed 6 staff members about the allegation of missing money on 7/11/24. Further review of the facility report revealed documentation that law enforcement was not notified of the allegation of stolen money. The initial report of this allegation of stolen money was sent to the the State office on 7/12/24 at 5:30 PM. This is the day after the allegation was made and the investigation was initiated. On 8/29/25 at 9:17 AM when asked about reporting allegations to the police, the Nursing Home Administrator (NHA) reported they usually have a conversation with the family about notifying the police. Surveyor informed the NHA that no documentation was found to indicate there was any conversation about notifying the police. Surveyor also reviewed the concern that the allegation of theft was not reported to the state office until the day after the allegation was made. 3) Review of facility reported incident #337735 revealed that it was an allegation of abuse made by Resident #77. The initial report was received by the State office on 9/18/24. The alleged perpetrator was a geriatric nursing assistant (GNA #24). Review of the investigation documentation revealed that on 9/17/24 the Director of Nursing (DON) received a concern form, dated 9/15/24, from Resident #77 in which the resident requested the patient bill of rights and a patient advocate. The DON met with the resident on 9/17 and again on 9/18. On 9/18/24 the resident reported an incident that occurred on the evening shift of 9/15/24 involving GNA #25. The resident also reported that he had spoken to Nurse #17 that evening and had not seen GNA #24 since that evening. Review of a statement, dated 9/18/24 and signed by Nurse #17, revealed that on the evening of the event the resident had reported the GNA was “being rough with [him/her]” and the nurse gave the resident a complaint form to fill out. On 8/27/25 at 4:51 PM the DON indicated that if a resident reports to a nurse that a staff member was rough with them she would expect the nurse to report this to either herself or the nursing home administrator (NHA). The DON reported that she was aware of the nurse’s statement from Resident #77 that was not reported, and she indicated she has addressed this issue with the nurse. On 8/29/24 at 12:10 PM surveyor reviewed the concern with the DON and the NHA the concern regarding failure to report allegations of abuse in a timely manner. (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) A review of a facility-reported incident #2564116 related to Resident #10 showed that the resident reported an allegation of abuse to staff #17, a licensed practical nurse (LPN), on 7/12/25. Further review of the facility's investigation into the allegation revealed that Resident #10 made the allegation to Staff #17 on 7/12/25, at 12:40 AM. The Nursing home administrator (NHA) was notified of the allegation on 7/14/25. The incident was initially reported to the state agency on 7/16/25 at 3:22 PM, two days after it had been reported to the facility. During an interview with the Director of Nursing (DON) on 8/27/2025, at 4:52 PM, she mentioned that her expectation was for staff #17 to have reported the allegation to her immediately; however, this did not occur. The DON verbalized understanding of the concern of not sending an initial report of the alleged abuse to the state agency, but not later than 2 hours after the facility staff became aware of the allegation. 5) A review of a facility-reported incident #337744 contained an allegation made by Resident #71 on 2/25/25 of missing money from his/her room. A continued review of the facility's investigation file revealed that the allegation of missing money was initially reported to the state agency on 2/28/25 at 5:44 PM. The final report was completed on 3/11/25, at 2:25 PM, indicating that once the facility became aware of the allegation, the staff failed to forward a first report to the state agency within two hours and a final report within five business days. In an interview with the Nursing home administrator on 8/28/2025, at 5:13 PM, she verbalized understanding of the concern regarding not reporting the allegation of missing money to the office in a timely manner.

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	215247	A. Building B. Wing	08/29/2025

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Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and interviews, it was determined that the facility failed to develop comprehensive person-centered care plans for residents. This was found to be evident for 3 (#48, #83, #76) out of 43 residents reviewed during the survey. The findings include: 1) In an interview on 8/19/2025 at 3:11 PM, Resident #48 indicated that s/he required assistance from staff with his/her ADLs. A record review completed later that day showed that Resident #48 had been residing in the facility since June 2025. The review also included an MDS assessment for Resident #48, dated 8/1/25. The MDS recorded that the Resident required assistance from staff with most of his ADLs. However, a continued review of Resident #48's care plan failed to demonstrate that his/her ADL needs were addressed in the care plan. The care plan was not comprehensive and person-centered. In an interview on 8/25/2025, at 3:58 PM, the Director of Nursing (DON) confirmed that Resident #48's care plan did not capture his/her ADL needs. The DON said she would ensure that the care plan was updated.During an interview on 8/29/2025, at 9:46 AM, the DON stated that she updated Resident #48's care plan following the surveyor's intervention. 2) Resident #83 was admitted to the facility in May 2024 for therapy following a hospitalization. Review of the a 5/14/24 progress note revealed that the responsible party’s goal was for the resident to be discharged to an ALF [assisted living facility], but not the same ALF as the resident’s spouse. The note also revealed that the responsible party had not located an alternative placement at that time. Review of complaint 337726 revealed an allegation that the social worker offered no assistance in finding placement. Further review of the medical record revealed that on 5/14/24 a care plan was initiated with a focus of discharging to an assisted living facility (ALF) and a goal that the resident: will discharge to a safe setting of [his/her] family's choice by the end of the review period. There was only one intervention included in this care plan: Met with resident and resident representative as resident allows to discuss discharge needs. No documentation was found in the care plan in regard to facilitating the identification of an appropriate discharge location, or assisting with obtaining needed supplies and services upon discharge. On 8/26/25 at 3:06 PM the Social Service Director (SSD #1) reported that discharge planning starts on day of admission. She reported that if a resident is planning to go to an ALF she has resources that can help find a placement and that she does document when she provides this information. Further review of the medical record failed to reveal documentation to indicate the facility staff provided assistance with identifying a potential ALF placement for the resident. (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/25 during the 3:06 PM interview the Social Service Director (SSD #1) also indicated she assists with ordering Durable Medical Equipment and Home Health Care as part of discharge planning. No documentation was found in the care plan in regard to facilitating the identification of an appropriate discharge location or assisting with obtaining needed supplies or services upon discharge. On 8/29/2025 at 10:05 AM surveyor reviewed the concern with the Director of Nursing (DON) that the resident's care plan for discharge on ly included that staff would discuss discharge needs with the family. DON acknowledged the concern. Cross reference to F 628 3) Resident #76 was admitted to the facility in January 2025. Review of the admission Minimum Data Set (MDS) assessment, with an assessment date of 1/19/25, revealed that the resident was occasionally incontinent of urine. Review of the Care Area Assessment (CAA) Summary section of the MDS revealed the care area of urinary incontinence had triggered and a decision was made to address urinary incontinence in a care plan. Review of the care plans for Resident #76 failed to reveal incontinence was addressed in a care plan. On 8/25/25 at 3:51 PM the Director of Nursing (DON) reported that, in regard to the CAAs, the idea is to set the care plan up for whatever the trigger is. Surveyor reviewed the concern that the CAA indicated a care plan would be developed to address urinary incontinence, but none was found. The DON confirmed that she did not see a care plan addressing the urinary incontinence. A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Staff utilize care plans to provide resident-centered care that includes support, services, and resources tailored to address each Resident's specific needs. The Minimum Data Set (MDS) is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions.

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	215247	A. Building B. Wing	08/29/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews, it was determined that the facility failed to accurately document care in the resident's medical record. This was evident for one (Resident #36) out of two residents reviewed for urinary catheter care.The findings include:Resident #36 has a history of hypertension (high blood pressure), dysphagia (difficulty swallowing), bladder dysfunction requiring a catheter, dementia, anxiety, and depression.On 8/20/2025 at 4:10 PM, the surveyor reviewed Resident #36's Medication and Treatment Order records and noted multiple blanks (not documented as completed) under the ordered care, as detailed below:Missed Medications on 8/9/2025 at 9:00 AM: Amlodipine 5 mg Aspirin 81 mg Escitalopram Oxalate 5 mg Furosemide 20 mg Levothyroxine 50 mcg Preservision (Multivitamin with minerals) Colace 100 mg Sennosides 8.6 mg Healthshake 4 oz Refresh Plus eye drop 0.5%Missed Treatments (dates as noted): Licensed nurse to complete a full body and skin assessment, including any findings. Missed on 8/19/2025 (day shift). Pain evaluation for verbal and nonverbal signs and symptoms every shift. Missed on 8/9/2025, 8/10/2025, 8/15/2025, 8/18/2025, and 8/19/2025 (day shifts). Antifungal external powder applied daily and evening shifts. Missed on 8/9/2025 and 8/15/2025 (day shifts). Flush Foley catheter with 30 cc of normal saline. Missed on 8/9/2025, 8/10/2025, 8/15/2025, and 8/18/2025 (day shifts). Pressure-reducing cushion to wheelchair when out of bed. Missed on 8/9/2025, 8/10/2025, 8/15/2025, and 8/18/2025 (day shifts). Appraise and observe resident for changes in physical or mental status every shift. Missed on 8/9/2025, 8/10/2025, 8/15/2025, 8/18/2025, and 8/19/2025 (day shifts). Enhanced barrier precautions. Missed on 8/9/2025, 8/10/2025, 8/15/2025, 8/18/2025, and 8/19/2025 (day shifts). Enter the number of behavioral occurrences that occurred during the shift. Missed on 8/9/2025, 8/10/2025, 8/15/2025, and 8/18/2025 (day shifts). Monitoring for psychotropic medication side effects. Missed on 8/9/2025, 8/10/2025, 8/15/2025, 8/18/2025, and 8/19/2025 (day shifts).On 8/20/2025 at 4:18 PM, the surveyor interviewed the Director of Nursing (DON) and asked what it means when boxes are blank on the medication and treatment records. The DON replied that it was not documented as done or not done. The surveyor pointed out several instances of missed care on 8/9/2025, 8/10/2025, 8/15/2025, 8/18/2025, and 8/19/2025. The DON agreed that this was concerning, stated she would investigate it, and acknowledged that the gaps in documentation appearing to show care was not performed.On 8/21/2025 at 12:00 PM, the DON requested to speak with the surveyor regarding the documentation gaps for Resident #36. She stated that after the discussion the previous day, she audited the [NAME] Wing records for August 2025 and identified that all missed documentation was linked to one nurse.The DON reported that she contacted the nurse (#12), who claimed she had provided the care but had failed to document it. The DON asked Nurse #12 to provide attestations for all the dates in question and supplied these attestations to the surveyor. The DON acknowledged that several medications and treatments had not been documented as completed in August 2025 and stated she wanted the surveyor to see that she was taking the issue seriously after it was brought to her attention.The DON also identified that 30 other residents had been affected by Nurse #12 not documenting care as ordered. She provided attestations for those residents as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on a review of employee education files and staff interviews, it was determined that the facility failed to provide Quality Assurance and Performance Improvement (QAPI) training to employees. This was evident in five out of five employee records reviewed for the staffing task.The findings include:A QAPI program is a structured way for a facility to make sure resident care is good and continues to improve. It includes participation from staff, residents, and their families.On 8/25/25 at approximately 2:45 PM, the surveyor performed a review of employee education files. The surveyor reviewed Staff #12, #13, #14, #15, and #16 and was unable to find evidence that they had received training about the facility QAPI program.On 8/26/25 at 9:15 AM, the surveyor interviewed the Nursing Home Administrator (NHA), who stated that she had provided QAPI training to staff at one point and would look for evidence. Later that morning, she explained that the training had been quite a while ago and that there was nothing current to show. She also stated that she was not aware it was a mandatory requirement to provide training that outlines the facility QAPI program and informs staff of the elements and goals of the QAPI program. She added that she will begin this education immediately.

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	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and staff interviews, it was determined that the facility failed to notify an attending physician when there were documented changes in a Resident's condition. This was evident for 1 (#69) out of 15 Residents reviewed for Abuse.The findings include:A review of a facility-reported incident (#337746) revealed an allegation of Abuse made by Resident #69.A continued review revealed that staff #8, a licensed practical nurse (LPN), had reported to Resident #69's representative on 4/6/25 that the Resident was more confused and agitated today. The nurse continued to report that Resident #69 had thrown [his/her] dinner tray at her. However, the review failed to show that Resident #69's attending provider was notified of the change in behavior. In an interview on 8/28/2025 at 4:33 PM, the Director of Nursing (DON) stated that the change in Resident #69's behavior on 4/6/25 was considered a change in condition and, therefore, expected a change in condition assessment form to be completed and notification of Resident #69's attending provider of the change. However, an earlier record review failed to show that staff #8 completed a change in condition assessment for Resident #69 and notified his/her attending provider of the change in behavior.During a subsequent interview on 8/29/2025, at 8:10 AM, the DON verbalized understanding of the concern regarding the failure to report a change in Resident #69's behavior to his/her provider.

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	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to 1) ensure appropriate information was communicated to the receiving health care institution to ensure an effective transition of care and 2) provide a written transfer notice and a written bed hold policy to a Resident's representative upon transfer to an acute care facility. This was evident for one (#83) out of three residents reviewed for discharge and for one (#4) out of two residents reviewed for hospitalization.The findings include: 1) Review of Resident #83’s medical record revealed the resident was admitted to the facility in May 2024 for therapy following a hospitalization. On 5/14/24 a care plan was initiated with a focus of discharging to an assisted living facility (ALF). There was only one intervention included in this care plan: Met with resident and resident representative as resident allows to discuss discharge needs. No documentation was found in the care plan in regard to facilitating the identification of an appropriate discharge location, or assisting with obtaining needed supplies and services upon discharge. Review of complaint #337726 revealed concerns regarding coordination of care related to the discharge to an assisted living facility (ALF). a. The complaint alleged the information contained in the Resident Assessment Tool (RAT) did not align with information communicated during the care plan meeting, specifically in regard to urinary and bowel continence status and the presence of delusion/hallucinations. The RAT is an assessment tool used by ALF to help determine a resident’s level of care. Review of the RAT revealed that it is required to be completed within 30 days prior to admission to the ALF. Review of the Minimum Data Set (MDS- a standardized assessment tool used by nursing homes) with a reference date of 5/14/24 revealed the resident was frequently incontinent of bowel. Urinary incontinence was not assessed due to the presence of an indwelling urinary catheter at the time of the assessment. Further review of the medical record revealed the indwelling urinary catheter was discontinued after the resident was admitted . Review of the Geriatric Nursing Assistant (GNA) documentation for 5/15 through 5/21/24 revealed the resident was incontinent of urine at least one time a day on 6 of the 7 days reviewed. And the resident was incontinent of bowel on 4 of the 7 days reviewed. Review of the RAT that was provided to the ALF revealed it was signed by Nurse #12 on 5/21/24. In the section titled Elimination, the nurse marked Normal for both bladder and bowel, despite the option to mark occasional incontinence (less than daily) or daily incontinence. Review of the 5/14/24 MDS revealed documentation that the resident had experienced hallucinations during the assessment period. Review of the 5/17/24 nurse practitioner (NP #18) note revealed the following: “…reportedly hallucinating about a jet that was flying overhead…”. Further review of the 5/21/24 RAT revealed that in the Psychosocial section of the form the nurse marked N-never for hallucinations and delusions. (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

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Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The complaint alleged the facility failed to order the medical equipment agreed upon for discharge. The complaint states that during the 5/23 care plan meeting it was communicated to the family that the facility would order a walker, a wheelchair and a hospital bed. Review of the 5/23/24 Care Plan Note, written by Social Service Director (SSD #1) revealed: “W/C [wheelchair] and RW [rolling walker] will be ordered prior to d/c by SSD as well as HHC [home health care]”. Home health care can include: skilled nursing; home health aids; and physical, occupational, and speech therapy. Review of the medical record failed to reveal documentation to indicate orders for a wheelchair, rolling walker or home health care were processed by the SSD. During an interview on 8/26/25 at 3:06 PM the Social Service Director (SSD #1) indicated she assists with ordering Durable Medical Equipment and Home Health Care as part of discharge planning. The SSD reported that the rehab department will inform her what durable medical equipment is required and that she orders the equipment. She confirmed that if listed in the care plan note as equipment to be ordered prior to discharge then she would order prior to the discharge. Surveyor reviewed the concern that no documentation was found to indicate that a rolling walker or wheelchair were ordered prior to discharge. The SSD reported she may have had an intern at that time and indicated she would go check the notes. Review of the 5/30/24 nurse’s note revealed the resident was discharged to an ALF with family. The resident was transported via a wheelchair and per the DON “wheelchair will be ordered for [him/her] and sent to [name of ALF] and [s/he] can take ours. Made pt. [family] aware our wheelchair needs to come back to the facility when they get the new one delivered.” On 8/26/25 at 3:37 PM the SSD presented with paperwork that indicated the wheelchair was ordered by the DON and delivered on 6/3/24. On 8/26/25 at 5:34 PM surveyor reviewed the concern with the Director of Nursing (DON) that SSD had not ordered the wheelchair or rolling walker as indicated in the care plan meeting note. The DON reported that she herself had ordered the wheelchair. Further review of the medical record failed to reveal documentation regarding the ordering of a hospital bed as indicated in the complaint. However, the paperwork provided by the SSD for the ordering of the wheelchair included documentation that indicated the SSD had ordered a Semi Electric Hospital Bed with a requested delivery date of 5/29/24 but the order was canceled by the facility. On 8/26/25 at 3:37 PM the SSD reported : I can’t remember why they didn’t need it; I probably cancelled it but cannot recall why. Review of the Maryland Discharge Instructions form revealed it was signed as completed by SSD #1 on 5/22/24, and nurse #19 on 5/30/24, and included a signature of the responsible party on 5/30/24. In the section titled MEDICAL EQUIPMENT ARRANGEMENTS the area to mark no, yes or N/A was left blank; in the area to document the Medical Equipment Provider there was documentation: “[NAME]” but no contact information was provided, and in the area for Equipment provided by facility was also noted to be blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/25, at 3:37 PM, the SSD reported that on the Maryland Discharge Instructions documentation, there was an error in regarding the medical equipment, stating: it was initially through [NAME], and I didn’t update to Adapt Health. c. The complaint alleged the facility failed to order physical and occupational therapy for the continuation of care at the new facility. The complaint states that during the 5/23 care plan meeting it was communicated to the family that the facility would order physical and occupational therapy. During an interview on 8/27/25 at 8:17 AM the Nurse Practitioner (NP #18) reported that for discharges, she will put orders for home health into PCC [name of electronic health record system] and then the social worker sends it out to whatever [home health] company they are using. The NP confirmed that if a resident is being discharged to an ALF she would still complete a home health order. Review of the 5/29/24 Nurse Practitioner (NP #18) discharge note revealed “Discharge Instructions: Discharge to ALF with home health services.” Further review of the medical record revealed there was a corresponding order, dated 5/29/24 to discharge the resident from the skilled nursing facility on 5/30/24 with skilled nursing, physical and occupational therapy evaluation, and a home health aide. During an interview on 8/26/25 at 3:06 PM, when asked about home health services, the SSD reported she puts in orders for PT, OT and Speech, and confirmed these orders would be included for ALF discharges. Surveyor reviewed the concern that no documentation was found to indicate a home health referral was completed. In a follow up interview at 3:37 PM the SSD reported she did not order the home health services because the ALF that the resident went to has their own therapy department. Further review of the Maryland Discharge Instructions form revealed in the section for IN HOME CARE OR SERVICES was marked: No. Further review of this document failed to reveal documentation regarding the order for the therapy evaluations. The complaint alleged that when they arrived at the ALF, the ALF was awaiting paperwork from the facility. The Nursing Home Administrator reported on 8/29/25 at 12:15 PM that that they do fax the discharge orders over when a resident is discharged to an ALF and they do not just rely on family. Review of the medical record failed to reveal documentation to indicate the discharge orders, which included the orders for the therapy evaluations, was sent to the ALF. On 8/29/25 at 12:15 PM surveyor reviewed the concerns with the DON and the Nursing Home Administrator (NHA) regarding the failure to ensure required information was provided to the receiving ALF, failure to ensure equipment was ordered prior to discharge and failure to ensure orders for home health were communicated to the ALF. 2) A review on 8/25/2025 at 1:36 PM of Resident #4's medical record showed that s/he was transferred to an acute care facility on 5/14/25 due to a change in condition. A continued review showed that the residents' representative was not present at the time of transfer and was notified via telephone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, the review lacked documentation that the resident's representative was notified in writing of the facility's bed hold policy and a transfer notice, along with the reason for the transfer. In an interview on 8/25/2025, at 1:48 PM, the admissions director reported that she was responsible for mailing the facility's bed hold policy and transfer notice to residents' representatives. However, she only sent them to representatives of residents who were in the facility for a short stay, not to representatives of long-term residents. During an interview with the nursing home administrator on 8/25/2025, at 2:07 PM, she reported that the facility had stopped mailing written bed hold policies and written transfer notices to the representatives of long-term care residents to avoid confusion.

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	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **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 that Minimum Data Set (MDS) assessments were accurately recorded. This was evident for 3 (#54, #3, #2) of 43 residents reviewed during the survey.The findings include:The Minimum Data Set (MDS) is an assessment of the Resident that provides the facility with the necessary information to develop a plan of care, deliver appropriate care and services to the Resident, and modify the care plan based on the Resident's status. MDS assessments must be accurate to ensure that each Resident receives the care they need. 1) A record review on 8/20/2025 at 10:44 AM included an MDS assessment dated [DATE] for Resident #54. The MDS assessment had recorded that the Resident received 2 days of insulin injections. A continued review of Resident #54's medication administration records (MARs) from July 2025 to August 2025 showed no documentation of insulin use for the observation period of the MDS assessment. Further review of the record did not reveal a current attending provider's order for insulin use during the look-back period for the MDS assessment. In an interview on 8/29/2025, at 8:32 AM, staff #11, the MDS Coordinator, stated that her source of information for documenting medications on the MDS assessment was the Resident's MARs. However, an earlier review of Resident #54's MARs from July 2025 to August 2025 failed to show the use of insulin for the MDS observation period. The interview revealed that Resident #54's MDS dated [DATE] was recorded in error. Staff#11 indicated that she would correct the MDS assessment. 2) Resident #3 has a medical history of Peripheral Vascular Disease (PAD) (a condition in which arteries in the arms or legs become narrowed or blocked, reducing blood flow), heart disease, type 2 diabetes, and pressure ulcers. A pressure ulcer, also known as a bedsore, is skin and tissue damage caused by prolonged pressure on one area of the body. This pressure reduces blood supply, which can injure the skin and underlying tissues. On 8/19/2025 at 11:06 AM, during the initial resident screening, the surveyor noted that the system flagged Resident #3 for developing a new pressure ulcer after admission. The surveyor asked Resident #3 if they had developed a new pressure ulcer since admission, and they stated, I don't think I have. Slough in a wound is dead, yellowish or whitish tissue that separates from the wound bed, forming a soft, moist layer. Eschar is hardened, dry, black or brown dead tissue that forms a scab-like covering over deep wounds such as severe burns or ulcers. A venous ulcer is a non-healing sore on the lower leg caused by poor venous blood flow. An arterial ulcer is a painful, slow-healing sore, usually on the foot or lower leg, caused by poor arterial blood flow. A stage three ulcer is a deep, open wound that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extends through all layers of the skin into fatty tissue and often appears crater-like. On 8/21/2025 at 3:25 PM, the surveyor reviewed Resident #3's MDS assessments, which revealed the following: 1/17/2025 – Section M: Skin Conditions M0210 – Does this resident have one or more unhealed pressure ulcers/injuries? = Yes M0300 – Current number of unhealed pressure ulcers/injuries:o F. Unstageable (slough/eschar) = 1o Number present upon admission = 1 M1030 – Number of venous and arterial ulcers = 2 4/19/2025 – Section M: Skin Conditions M0210 – Does this resident have one or more unhealed pressure ulcers/injuries? = Yes M0300 – Current number of unhealed pressure ulcers/injuries:o C. Stage three pressure ulcer = 1^ Number present upon admission/reentry = 1o F. Unstageable (slough/eschar) = 0^ Number present upon admission = 0 M1030 – Number of venous and arterial ulcers = 1 On 8/21/2025 at 3:25 PM, the surveyor also reviewed Resident #3's medical record, which revealed the following: January 2025 Care Plan Impaired, non-pressure skin integrity related to vascular disease as evidenced by wounds on the left heel, left great toe, and right foot. Date initiated: 1/08/2025. Provide wound treatment as ordered. Date initiated: 1/08/2025. The surveyor was unable to find evidence of a pressure ulcer on the care plan. January 2025 Treatment Orders Cleanse left heel with normal saline, apply Medi honey alginate, cover with foam dressing every daytime shift, and cleanse with Dakin's solution. Start date: 1/09/2025. Apply Povidone-Iodine Solution 10% to top right foot and left toe once daily, leave open to air. Start date: 1/08/2025. The surveyor reviewed care plans, skin assessments, and treatment orders from February through August 2025 and was unable to find evidence of a pressure ulcer developing during that time. On 8/21/2025, at 4:11 PM, the surveyor interviewed the MDS Coordinator (MDS Nurse #11) and asked where she obtained data for Section M when completing assessments. She stated she uses various sources, including hospital discharge summaries, facility skin assessments, and wound care nurse documentation. The surveyor asked her to review Resident #3's MDS assessments from 1/17/2025 and 4/19/2025. Both documented pressure ulcers, but the surveyor was unable to find evidence of these in the medical record. MDS Nurse #11 stated she was not the coordinator at that time, but it appeared to be a mistake. She added that she would review the matter and follow up. On 8/21/2025 at 4:26 PM, the surveyor spoke with MDS Nurse #11, who confirmed that the MDS error had been made by a previous coordinator and that a correction would be submitted. On 8/21/2025 at 4:41 PM, the surveyor spoke with the Nursing Home Administrator, who confirmed she was made aware of the error by MDS Nurse #11 and that the facility would be submitting a correction. 3) Resident #2 has a medical history of major depression, dementia, and bipolar 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
	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/25 at 1:45 PM, the surveyor conducted a record review of Resident #2's MDS assessments. On 12/19/24 – Section I (Active Diagnoses) Psychiatric/Mood Disorder: I5800 – Depression = Yes I5900 – Bipolar disorder = Yes I6000 – Schizophrenia (e.g., schizoaffective and schizophreniform disorders) = No On 3/21/25 – Section I (Active Diagnoses) Psychiatric/Mood Disorder: I5800 – Depression = Yes I5900 – Bipolar disorder = Yes I6000 – Schizophrenia (e.g., schizoaffective and schizophreniform disorders) = Yes On 8/27/25 at 2:44 PM, the surveyor reviewed Resident #2's psychiatric progress notes and found a note entered by Certified Registered Nurse Practitioner (CRNP) #21 on 2/17/25. The note stated that the resident appeared stable, with no symptoms of psychosis, hallucinations, delusions, or mood instability. The plan was to continue current medications. Despite this, the diagnosis section listed a new diagnosis of schizoaffective disorder, bipolar type. On 8/28/25 at 11:56 AM, the surveyor interviewed CRNP #21 and questioned the addition of this diagnosis since no supporting evidence was found. CRNP #21 explained the process required to diagnose schizoaffective disorder and stated she would further investigate. When the surveyor pointed out that the note documented the resident as stable with no psychosis, hallucinations, or delusions, CRNP #21 acknowledged the concern. A Resident Assessment Instrument (RAI) Manual provides detailed instructions for completing resident assessments. On 8/28/25 at 4:14 PM, the surveyor interviewed the MDS Nurse Coordinator (MDS Nurse #11) and asked what information coordinators use to complete Section I – Active Diagnoses. She explained that she reviews medications, treatments, and notes from the past six months. When asked specifically about adding a diagnosis of schizoaffective disorder, she stated, I would look at the RAI manual to figure out what we must do. She added that she compares the current assessment with prior ones, confirms documentation supporting any new diagnosis, and contacts the physician if questions arise. When asked if she was aware of special rules surrounding adding a schizophrenia diagnosis, she responded that she would need to review the RAI manual but knew there were strict requirements for this diagnosis. The surveyor then asked her to review the MDS assessment dated [DATE] that listed schizoaffective disorder, bipolar type as a new diagnosis. She confirmed it was listed but was unsure if she had completed that assessment. When asked whether a wrong diagnosis would make the MDS inaccurate, she stated that if the diagnosis was not accurate, then the MDS would also be inaccurate. The Director of Nursing (DON) came into the room and agreed that the diagnosis was likely added by CRNP #21 by mistake, which would, in turn, make the MDS inaccurate. On 8/29/25 at 8:18 AM, CRNP #21 called the surveyor and stated, I reviewed the past two years of records, and you are correct, this should not have been a diagnosis and was likely a typographical error. I never should have done it. She said she would send an email to the DON to explain the error. On 8/29/25 at 9:03 AM, the surveyor informed the Nursing Home Administrator (NHA) and DON that the facility should expect the email. The NHA responded that she had already spoken with the group, was not surprised, and was expecting a correction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215247	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlee Hill Health and Rehab Center	297 Stoner Avenue Westminster, MD 21157

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/25 at 11:43 AM, the surveyor asked the NHA if the facility had received the email. The NHA said it had not yet been received but that she had texted CRNP #21 to request it. At the time of survey exit, the email had still not been received.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to provide residents/representatives with a copy of their baseline care plan, which included a summary of the Resident's medication. This was evident for 2 (#14, #83) of 43 residents reviewed during the recertification survey.The findings include:A baseline care plan is a document that outlines initial instructions for providing care to a resident in a long-term care facility, typically developed within 48 hours of admission. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive. 1) In an interview on 8/19/2025, at 8:49 AM, Resident #14's representative stated that he had not received a copy of the Resident's baseline care plan, including a list of his/her medications. A record review on 8/21/2025, at 10:52 AM, showed that Resident #14 was admitted to the facility on [DATE]. A continued review revealed that a baseline care plan dated 8/6/25 for Resident #14 had been initiated but was not completed. The review also contained another baseline care plan, dated 8/8/25, for Resident #14 that had been started and marked as complete, but was missing the staff and representative's signatures. In an interview with the director of nursing on 8/21/2025, at 2:24 PM, she reported that there was no documentation to show that a copy of Resident #14's baseline care plan, including a list of his/her medications, was given to the representative. 2) Resident #83 was admitted to the facility on [DATE], for therapy following a hospitalization. Review of complaint #337726 revealed a concern that the first care plan meeting was held 15 days following admission, and this meeting was the first time the level of care required was communicated to the family. Review of the Baseline Care Plan, signed as completed by the registered dietician (RD#) and nurse #12, revealed the resident was cognitively impaired and confused. Further review of the Baseline Care Plan revealed that a copy was given to the resident on 5/9/24. The area of the form to document the resident representative's signature was noted to be blank. Further review of the medical record failed to reveal documentation to indicate that a copy of the baseline care plan was provided to the resident's representative. Further review of the medical record revealed a note written by the Social Service Director (SSD #1) on 5/23/24, which revealed the interdisciplinary team met with the resident and the family on that date for admission care plan meeting. On 8/26/25, at 3:37 PM, when asked who provides the baseline care plan, the Social Service Director (SSD #1) reported she believed nursing does.On 8/26/25, at 5:34 PM, the surveyor reviewed the concern with the Director of Nursing (DON) that the family had not been provided a copy of the baseline care plan. DON reported it was provided to the resident. As of the time of survey exit on 8/29/25, no documentation was provided to indicate that the baseline care plan had been provided to the family.

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	215247	A. Building B. Wing	08/29/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record reviews and interviews, it was determined that the facility failed to provide evidence to support a diagnosis of schizoaffective disorder. This was evident for 1 (Resident #2) of 6 residents reviewed for unnecessary medications.The findings include:According to facility medical records, Resident #2 has a medical history of major depression, dementia, bipolar disorder, and schizoaffective disorder, bipolar type.Schizophrenia is a severe and persistent mental disorder that affects how a person thinks, feels, and behaves. It can cause abnormal interpretations of reality and disruptions in a person's thought processes, perceptions, emotional responses, and social interactions.A Minimum Data Set (MDS) is a standardized assessment tool used to evaluate the health status of residents in long-term care facilities. The information helps facilities create care plans based on the residents' needs. MDS assessments are required for all residents.On 8/27/25 at 1:45 PM, the surveyor reviewed Resident #2's MDS assessments.On 12/19/24, Section I (Active Diagnoses) Psychiatric/Mood Disorder showed: I5800 - Depression = Yes I5900 - Bipolar disorder = Yes I6000 - Schizophrenia (e.g., schizoaffective and schizophreniform disorders) = NoOn 3/21/25, Section I (Active Diagnoses) Psychiatric/Mood Disorder showed: I5800 - Depression = Yes I5900 - Bipolar disorder = Yes I6000 - Schizophrenia (e.g., schizoaffective and schizophreniform disorders) = YesOn 8/27/25 at 1:57 PM, the surveyor reviewed Resident #2's medication orders, which showed the following: Escitalopram 20 mg - one tablet daily for depression, start date 9/18/24 Divalproex Sodium 250 mg - one tablet twice daily for bipolar disorder, start date 12/26/24 Risperidone 0.5 mg - one tablet twice daily for schizoaffective disorder, start date 3/11/25On 8/27/25 at 2:44 PM, the surveyor reviewed Resident #2's psychiatric progress notes. The 2/17/25 note, entered by Certified Registered Nurse Practitioner (CRNP) #21, documented that the resident appeared stable with no symptoms of psychosis, hallucinations, delusions, or mood instability. The plan was to continue current medications. Despite this, the diagnosis section included schizoaffective disorder, bipolar type.Earlier psychiatric notes did not list schizoaffective disorder as a diagnosis.On 8/28/25 at 10:40 AM, the surveyor interviewed the Director of Nursing (DON) while reviewing Resident #2's Order Audit Report dated 3/11/25. The report showed that a new order for Risperidone 0.5 mg twice daily was entered for schizoaffective disorder. The DON confirmed she entered the order based on a verbal order from (Nurse Practitioner) NP #18. Previously, the same dose of Risperidone had been prescribed for bipolar disorder versus schizoaffective disorder.When asked why the new diagnosis was added, the DON stated she knew psychotropic medications could negatively affect elderly residents and could also impact the facility's star rating. She explained, I asked CRNP #21 to review Resident #2 for the use of Risperidone. I knew the resident had been doing okay and asked for a review to consider a Gradual Dose Reduction (GDR). She added that the schizoaffective disorder diagnosis was entered after that request.On 8/28/25 at 11:56 AM, the surveyor interviewed CRNP #21. The conversation is summarized below:The surveyor asked if CRNP #21 was familiar with Resident #2. She replied that she was and believed she had last seen the resident around March 2025.The surveyor asked what conditions she had been treating. She stated, I have seen Resident #2 since around 2022, and I am pretty sure I was seeing them for depression, bipolar disorder, and dementia.The surveyor then asked if she remembered adding a diagnosis of schizoaffective disorder, bipolar type, on 2/17/25. She replied, This was added as a differential diagnosis because of behaviors, delusions, irritable mood, and depression. Yes, I added the diagnosis.The surveyor asked what she meant by differential diagnosis. She replied, This means a resident can have a different diagnosis based on their presentation.The surveyor noted that her progress notes from 2/17/25 described the resident as stable with no psychosis or delusions. The surveyor read the assessment back to her. Met patient resting in [their] room. On assessment today, the patient appeared calm, cooperative, and pleasantly engaged, though confused. S/he reported a stable mood, appetite, and sleep. S/he denied any clinical signs or symptoms of anxiety or depression. Staff reported that [their] mood and behavior were at baseline, with no acute distress or (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns. No behavioral abnormalities were observed or reported. No agitation, anxiety, or mood lability was noted. There were no signs or symptoms of delusions, hallucinations, or other psychotic processes. No feelings of hopelessness or worthlessness were reported. The patient denied low energy, lack of motivation, death wishes, suicidal ideation or intent, and any visual or auditory hallucinations or delusional thoughts. No clinical worsening of depression, anxiety, or unusual behavior changes was noted.After hearing it, CRNP #21 stated, I am pretty sure that something happened to cause me to add this diagnosis even though my note doesn't explain the justification. I need to be able to look into the notes.The surveyor asked, What does the Diagnostic and Statistical Manual of Mental Disorders (DSM) say about adding a diagnosis of schizoaffective disorder? CRNP #21 replied, The patient must meet the criteria such as a psychosis episode, depressive or manic irritability, or hallucinations and behaviors. basically depression symptoms and a psychosis episode.**The DSM is the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. DSM contains descriptions, symptoms and other criteria for diagnosing mental disorders.The surveyor then asked, Where does your documentation support that the resident displayed those behaviors? CRNP #21 replied, I don't know. I will have to look at my notes.The surveyor asked, What do DSM guidelines say about the timeline for symptoms before a diagnosis can be made? She answered, The timeline depends on the onset, but you see it repeatedly before the diagnosis. Sometimes they might have an alcohol-related psychosis only one time, so it would depend on seeing them more to determine a true diagnosis.The surveyor asked, Where does the record show that Resident #2 had repeated issues, behaviors, or hallucinations? She replied, I would need to look at my notes for this.The surveyor asked if she would be expected to tell the resident or family if she added a new diagnosis. She agreed and acknowledged her own note from 2/17/25, which stated there was no communication with the responsible party because there was no significant change in the resident's condition or plan of care. The surveyor asked, Why didn't you do that for this resident since you added the diagnosis? She replied, I would need to look at the record.The surveyor asked CRNP #21 to review the resident's notes and report back.On 8/29/25 at 8:18 AM, CRNP #21 called the surveyor and stated, I reviewed the past two years of records, and you are correct, this should not have been a diagnosis and was likely a typographical error. I never should have done it. She said she would send an email to the DON to explain the error.On 8/29/25 at 9:03 AM, the surveyor informed the NHA and DON that the facility should expect the email. The NHA said she had already spoken with the group and was not surprised, and was expecting a correction.On 8/29/25 at 11:43 AM, the surveyor asked the NHA if the facility had received the email. The NHA said it had not yet been received but that she had reached out to CRNP #21 by text to request it. At the time of survey exit, the email had still not been received.

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	215247	A. Building B. Wing	08/29/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to ensure that a resident who required assistance with Activities of Daily Living (ADL) was provided with showers. This was evident for 1 (#48) of 3 Residents reviewed for ADLs. The findings include:In an interview with Resident #48 on 8/19/2025 at 3:11 PM, s/he indicated that s/he would like to get more showers than were offered as of the time of the interview.A record review showed that Resident #48 had been in the facility since June 2025. A continued review included an MDS assessment dated [DATE], for Resident #48, which recorded that the resident required staff assistance with showering.The Minimum Data Set (MDS) is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions.A subsequent record review on 8/25/25, at 3:14 PM, of the GNA (Geriatric Nurse Aid) shower documentation from July 2025 to August 2025, noted no showers for July and one shower for August. An interview later that day with staff #20, a Geriatric Nurse aid (GNA), revealed that Resident #48 was scheduled to have two showers per week; however, an earlier record review noted only one shower from July 1, 2025, to August 25, 2025.In an interview on 8/25/2025, at 4:15 PM, the Director of Nursing reported that Resident #48 had a shower on 8/19/25. The DON confirmed the lack of documentation for the resident's showers for the other days from July 1, 2025, to August 25, 2025.

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	215247	A. Building B. Wing	08/29/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews, it was determined that the facility failed to ensure that care was provided in accordance with professional standards and physician orders. This was evident for 3 (#75, #76, and #79) of 5 residents reviewed in relation to complaint investigations.The findings include:1) Resident #79 was admitted to [NAME] Hill Nursing and Rehab Center following a hospitalization for dyspnea (shortness of breath or difficulty breathing). Their medical history included Congestive Heart Failure (weakened heart muscle that makes pumping blood difficult for the heart), Atrial Fibrillation (irregular and sometimes rapid heart rate), and hypertension (high blood pressure). On 8/21/2025, the surveyor reviewed a Facility Reported Incident (FRI) #337732 and a correlating complaint #337733 that were reported to the Office of Healthcare Quality (OHCQ) regarding a medication error involving Resident #79. The FRI document submitted to OHCQ by the facility’s Nursing Home Administrator (NHA), revealed in part that Resident #79 was transferred to [name of hospital] emergency room on 8/25/24, per the request of their family member, due to hypotension [low blood pressure]. On 8/26/24, [NAME] Hill’s Medical Director received an update from the hospital indicating that the resident had initially arrived at [NAME] Hill with a medication order for Carvedilol 25 mg, 1/2 tablet, twice daily. The facility transcribed the order as Carvedilol 25 mg, 1 tablet, twice daily. The facility’s report stated, “The investigation revealed a breakdown in the admission process. The nursing department did not complete the admission checklist or have a second nurse review the admission for accuracy. Had the process been followed, the transcription error would have likely been identified.” The surveyor also reviewed complaint #337733, submitted by a family member, which stated in part that their family member was admitted to [NAME] Hill for physical therapy after a hospital stay. They reported that “The admissions staff assured me that I didn’t need to go over the medication list because it was in their system since [NAME] Hill is part of the transferring hospital’s network.” The complaint further stated that on 8/25/24 the family member visited and observed that Resident #79 was “very out of it” and when their morning vitals were taken, their blood pressure [BP] was only 80/30. The complainant reported that the Director of Nursing (DON) later called to discuss the mistake and explained that the facility had discovered they had been giving the resident twice the amount of Carvedilol prescribed. On 8/25/2025 at 8:33 AM, the surveyor interviewed the family member who submitted the complaint. They stated that Resident #79 had been given the wrong dose of medication which resulted in “very low blood pressure and difficulty breathing which required hospitalization.” They confirmed that the DON contacted them after the hospitalization to notify them of the error and to apologize. On 8/25/2025 at 9:48 AM, the surveyor reviewed Resident #79’s medical record which revealed that on 8/23/24, the facility entered an order for “Carvedilol 25 mg, give one tablet by mouth two times a day for hypertension. Start date 8/23/24.” Review of [NAME] Hospital’s Discharge summary dated [DATE] revealed that the correct medication order was Carvedilol 25 mg oral tablet, 12.5 mg = 0.5 tablet by mouth twice daily. (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital discharge summary for Resident #79’s stay from 8/25/24 to 8/27/24 revealed the following: The medication list from [NAME] Hill was reviewed. It showed that the facility either increased or incorrectly recorded the resident’s Carvedilol (Coreg), doubling the previous dose from 12.5 mg twice daily to 25 mg twice daily. Emergency Medical Services (EMS) documented blood pressures of 90/40 and 91/36. In the Emergency Department (ED), the initial blood pressure was 91/36 with excellent oxygen saturation on 2L Oˆ. Blood pressure gradually improved to 120/50. Laboratory results demonstrated mild acute kidney injury (AKI), with creatinine rising to 1.5 from 0.73 on 8/23/24. Blood urea nitrogen (BUN) doubled to 30 [elevations in creatinine and/or BUN [may indicate kidney dysfunction or dehydration]. S/he was started on gentle IV fluids. The patient was admitted under observation for hypotension and AKI, suspected to be caused by fluid depletion related to the patient's congestive heart failure (CHF). Further surveyor review of the facility Medication Administration Record showed that the resident received the wrong dose of Carvedilol on 8/23/24 at 8:00 PM, on 8/24/24 at 8:00 AM and 8:00 PM, and on 8/25/24 at 8:00 AM. Review of Resident #79’s vital signs from admission until transfer to the hospital showed the following:• 8/23/24 – BP 125/74, Pulse 69• 8/24/24 – BP 132/74, Pulse 82• 8/25/24 – BP 80/40, Pulse 58 The surveyor reviewed Resident #79’s progress notes:On 8/25/24 at 10:43 AM, Nurse #9 entered a “Health Status Note,” which documented that the resident was sent to [Omitted] Hospital Center via 911 due to a manual blood pressure reading of 80/40 and at the request of their [family member]. Heart rate at the time of discharge was 58. Baseline blood pressure the previous day was 120–140s/70s. The resident also reported shortness of breath while on 3 liters of oxygen via nasal cannula. Nurse #9 also entered an SBAR [a medical note that some healthcare facilities use to communicate the resident’s Situation, Background, Assessment, and Recommendation] dated 8/25/24 at 10:27 AM, which revealed in part:Situation: Change in condition included shortness of breath.Vital signs: Blood Pressure 80/40, pulse 58, respiratory rate 20, temperature 98.0.Provider feedback: The physician was contacted and instructed the facility to transfer the resident to the ED per family request. On 8/26/2025 at 3:12 PM, the surveyor interviewed Staff Nurse #10 about the admission process for incoming residents. She stated that before admission, the admission Coordinator brings paperwork to the nurse, which includes information about medications and supplies needed for care. Orders are put into a queue, and the Medical Director reviews them, either approving or making changes. The Medical Director also calls to verbally review all orders with nursing staff. She added that the pharmacy cannot see the orders until after the Medical Director reviews them and the orders are released from the queue. Occasionally, the pharmacy may be aware of the medications beforehand, but she is unsure how. (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor asked if there is a checklist for admission, and she stated that there is. She provided the surveyor with the “[NAME] Hill admission Checklist-Nurses (updated 8/28/24),” which lists tasks for nurses to complete. Number 7 states, “Enter all approved orders into PCC and batch orders.” On 8/26/2025 at 3:32 PM, the surveyor interviewed the DON about FRI #337732. The DON admitted that the facility made a transcription error and that both the first and second nurses had not completed the admission checklist. She acknowledged that if the protocol had been followed, the error likely would not have occurred. The DON stated that the physician did not believe transfer was necessary because the resident was asymptomatic. The surveyor pointed out that documentation showed the resident had been short of breath. The DON reviewed the record and admitted she was unaware the resident’s symptoms had been documented. The DON provided a Performance Improvement Plan (PIP) titled “Transcription Error August 2024,” which focused on the second nurse chart review. When asked if she investigated why the checklist had not been completed by the first and second nurses, the DON replied “No, it was just a finding.” She stated she had not asked the nurses why they did not complete it. When asked why the PIP focused only on the second check, the DON stated that she considered the second check more important because the “second nurse would likely find an error”. On 8/26/2025 at 4:20 PM, the surveyor reviewed a “Pharmacy Medication Review” note entered by the pharmacist (Staff #7) dated 8/23/24 and signed on 9/30/24, which stated “No major concerns at this time.” On 8/27/2025 at 8:22 AM, the surveyor reviewed a document titled “Incident Investigation” dated 8/26/24 through 8/30/24, that was provided by the NHA and written by the DON. It revealed, in part:Type of Incident: Medication transcription error with transfer to ED.Details: A new admission medication was transcribed incorrectly. On day two, the patient required transfer to the ED for evaluation of hypotension.Findings included: Carvedilol 25 mg ordered as 0.5 tablet BID [twice daily] was transcribed as 25 mg BID. The patient received four incorrect doses. admission BP was 125/74, pulse 69. On 8/25/24, BP was 80/40, pulse 58. The report concluded that “a transcription error was made given the way the discharge summary was written” and that the transfer was unnecessary as the patient did not require aggressive measures. It stated that the resident did not suffer serious bodily injury and was discharged home within a few days. The investigation also noted that the nursing department did not complete the admission checklist or second nurse review. On 8/27/2025 at 2:20 PM, the surveyor interviewed the consultant pharmacist (Staff #7). She stated that she receives notification of admissions, compares the facility’s orders to the hospital discharge summary, and emails the DON and Medical Director if discrepancies are identified. She stated, “This is a checks and balances system to ensure accuracy of the medication orders.” When asked if she documents this review, she stated, “Yes, the note is called admission Medication Review.” The surveyor showed the pharmacist the “admission Medication Review” she completed on 8/23/24 for Resident #79, in which she wrote, “no major concerns at this time,” and she acknowledged that she should have caught the error. On 8/28/25 at 5:13 PM, the surveyor spoke with both the DON and NHA to discuss potential citations identified during the survey, specifically concerning the medication error that occurred in August 2024. Both the NHA and DON agreed that the error resulted from a transcription mistake; however, (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they stated that the resident could have been treated in the facility without transferring them to the hospital. The DON noted that the family requested the transfer, but the physician felt he could have managed the resident without the transfer. 2) A review of complaint #337738 contained an allegation that staff failed to assess and give medication to Resident #75 when s/he complained of chest pain. Continued review of Resident #75's record included a nurse's note dated 10/19/24 that stated Reported from previous shift that Resident [complained] of chest pain through the night. She was given prn [as needed] Zofran. Further review showed that the Resident's medical history included chest pain secondary to unstable angina and had an attending provider's order to have Nitroglycerin Tablet Sublingual 0.4 MG Give 1 tablet sublingually every 5 minutes as needed for Chest Pain x 3 doses. However, the review showed that staff gave him/her antiemetic medicine instead of the chest pain medication. The review also failed to demonstrate that staff assessed the Resident for the change in condition, and notified the attending provider of the change in condition. In an interview on 8/28/2025, at 3:57 PM, Staff #10, a Registered Nurse (RN), reported that she had received a report on the morning of 10/19/24, from the outgoing night nurse stating that Resident #75 had complained of chest pain during the night and was given an antiemetic medication. Staff #10 said the Resident was stable when she started her shift. However, the Resident requested to be transferred to the hospital to be evaluated for a heart attack because of his/her history, so s/he was transferred to the hospital. 3) Resident #76 was admitted to the facility on [DATE] after a brief hospitalization. The resident's weight on 1/13/25 was documented as 195.8 lbs. Review of a care plan for risk for weight loss, initiated 1/14/25, revealed that one of the interventions was to obtain the resident's weight per facility policy/physician order. Review of the facility's weight policy revealed a resident was to be weighed on date of admission, on day 2 of admission and then weekly for 4 weeks. Review of the Treatment Administration Record (TAR) revealed there was an order for admission weight day 2: obtain and document in PCC [name of electronic health record system]. In the area of the TAR to document the day 2 weight, on 1/14/25, was noted to be blank. Review of the Registered Dietician's note, dated 1/14/25, revealed the resident's admission weight was 195.8 lbs. There was also a notation that according to the resident his/her usual body weight was 199-200 lbs. Further review of the medical record failed to reveal documentation to indicate a weight was obtained, or attempted to be obtained, between 1/14-1/18/25. Further review of the medical record revealed on 1/19/25 the resident's weight was 177 lbs. A re-weight was obtained on 1/20/25 and the weight was 175.6. This significant weight loss was reported to the primary care provider and the dietician. On 1/21/25 the dietician wrote a note which indicated that, after discussion with the resident, the dietician Will strike out initial wt. as incorrect. (continued on next page)

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	215247	A. Building B. Wing	08/29/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed there was an order for weekly weights x 4 weeks. Review of the TAR revealed these weights were due to be obtained on 1/27 and 2/3/25. No documentation was found to indicate weights were obtained, as ordered, on 1/27 or 2/3/25. Nursing staff documented NA indicating not applicable in the space to document the weight on 2/3/25. Further review of the medical record failed to reveal documentation to indicate a weight was obtained, or attempted to be obtained, between 1/21/25 and the resident's discharge in February. On 8/25/25 at 3:03 PM surveyor reviewed the concern with the Director of Nursing (DON) that there were orders for weights that were not obtained. The DON responded: I don't know what happened to the one on the 27th. Surveyor also informed the DON that no documentation was found for the weight on the second day of admission. As of time of survey exit on 8/29/25 no additional documentation was provided to indicate additional weights were obtained during the resident's admission.

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	215247	A. Building B. Wing	08/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to provide necessary treatment and services to promote the healing of pressure ulcers. This was evident for 1 (#14) out of 3 residents reviewed for pressure ulcers during the survey.The findings include:A review of Resident #14's medical record on 8/19/2025 at 9:08 AM revealed the Resident was admitted to the facility in August 2025 with a noted open wound to the sacral area with no measurements.A continued review included a skin/wound note dated 8/11/25 that showed that the Resident was assessed to have a right buttock/sacrum stage 3 pressure sore (A pressure sore or injury is a localized area of skin damage that develops over a bony prominence or other hard surface due to prolonged pressure, shear, or friction). According to the note, Resident #14 reported that the wound was an existing wound upon admission.Further review of Resident #14's admission MDS, dated [DATE], noted that the Resident had a stage 3 pressure ulcer, which was present on admission.The Minimum Data Set (MDS) is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions.However, a review of Resident #14's order summary report as of 8/19/25 showed that the facility staff failed to implement any wound treatment for the Resident's stage 3 pressure ulcer until 8/12/25, 7 days after admission to the facility. In an interview with the Director of Nursing (DON) on 8/21/2025, at 2:24 PM, she confirmed that Resident #14 was assessed to have a sacral stage 3 wound upon admission. However, staff only applied incontinence care cream every shift. During a subsequent interview on 8/25/2025, at 9:06 AM, the DON reported that after the surveyor's findings regarding the delay in implementing treatment for Resident #14's wound, she conducted an audit to address the issue.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and staff interviews, it was determined that the facility failed to ensure a resident received their medication according to the attending physician's order. This was evident for one out of 5 complaints reviewed during the survey.The findings include:A review of complaint #337738 contained an allegation that staff failed to assess and give medication to Resident #75 when s/he complained of chest pain.A continued review showed that the Resident's medical history included chest pain secondary to unstable angina and had an attending provider's order to have Nitroglycerin Tablet Sublingual 0.4 MG Give 1 tablet sublingually every 5 minutes as needed for Chest Pain x 3 doses.Further review included a nurse's note dated 10/19/24 that stated Reported from previous shift that Resident [complained] of chest pain through the night. She was given prn Zofran. The review failed to show that Resident #75 was given Nitroglycerin when s/he complained of chest pain.In an interview on 8/28/2025 at 3:57 PM, Staff #10, Registered nurse (RN), reported that she had gotten a report on the morning of 10/19/24 from the outgoing nurse that Resident #75 had complained of chest pain during the night and was given an antiemetic drug.During an interview on 8/29/2025, at 11:10 AM, the Director of Nursing stated that Resident #75 had an attending provider's order for a drug for chest pain. So, she expected that her staff would have given Resident #75 his/her angina medicine when s/he complained of chest pain and not an antiemetic drug.

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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 medical record review, observation and interview it was determined that the facility failed to maintain a medication error rate of less than 5%. This was found to be evident for one (Resident #37) out of the four residents observed for mediation administration as evidenced by two errors out of 25 opportunities for error.The findings include: On 8/20/25 at 8:37 AM surveyor observed the Certified Medication Aide (CMA #6) prepare and administer the medications for Resident #37. The CMA prepared a total of six medications: Carbidopa/Levodopa; metformin; a multivitamin; omeprazole; Sertraline; and liothyronine. Prior to administering the medications the CMA confirmed six medications were going to be administered to the resident. The CMA reported that she had administered the resident's synthroid earlier in the day. After the observation, surveyor reviewed the resident's current medication orders which revealed that in addition to the six medications administered, there were orders for two additional medications scheduled to be given at 9:00 AM: Meclizine for vertigo (dizziness); and Acetaminophen for wound pain. Review of the Medication Administration Record at this time failed to reveal documentation from CMA #6 in the area to document the 9:00 AM administration for either of these medications. The CMA had not mentioned either of these medications at the time of the observation.On 8/20/25 at 9:32 AM when surveyor informed the CMA that the surveyor had a few questions, the CMA immediately said: I forgot the Tylenol (acetaminophen) because [resident] always refuses it because s/he says it makes him/her sick to his/her stomach.Further review of the Medication Administration Record revealed the resident had received the morning dose of acetaminophen on 6 out of the 7 mornings between 8/13 and 8/19/25. On 8/20/25 at 9:32 AM when surveyor reviewed the concern with the CMA that there was an order for the Meclizine to be given at 9:00 AM, the CMA proceeded to look in the medication cart and found the medication. CMA stated: I overlooked that one.On 8/20/25 at 10:05 AM the Director of Nursing (DON) reported she had followed up with the CMA after the surveyor finished speaking with her and that she was aware of the the omission of two medications. Surveyor informed the DON of the observation and interview with the CMA, and reviewed the error of omission of the acetaminophen and the meclizine. The DON acknowledged the concerns and indicated she would be addressing the issue.On 8/21/25 at 12:17 PM surveyor informed the DON of the medication error rate of 8% due to two errors out of 25 opportunities for error.

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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 record review, observations, and interviews, it was determined that the facility failed to ensure that residents were served meals according to a predetermined menu that incorporated their preferences. This deficient practice has the potential to affect all residents. The findings include:A review of complaint #337742 revealed an allegation that the meals delivered to the residents did not match what was stated on the menu.While observing the breakfast tray line on 8/26/2025, at 7:39 AM, the surveyor requested a test tray. The tray contained a meal ticket for Resident #46. The listed food items on the meal ticket to be served to Resident #46 were: 3 oz biscuit with sausage gravy, 6 oz Cheerios, 6 oz orange Juice, 8 oz 2% milk, one bottle of water, pepper, and two packets of sugar.However, continued observation failed to show that Resident #46's tray contained the portion sizes listed on the meal ticket for the resident's Cheerios and orange juice. Staff #23, the Dietary Director, was present and asked about the portion size for the Cheerios and orange juice. Staff #23 measured the Cheerios with a 6 0z measuring spoon and said it was 5 oz instead of 6oz. Staff #23 also measured the orange juice with a measuring cup and said it was 4.5 oz instead of 6 oz.In an interview, Staff #23 stated that before the surveyor's intervention, his staff was not aware that the cup they served residents' juice with was not an 8-oz cup but a 4.5-oz cup. Staff continued to state he would place an order for the right size of cups. Staff #23 verbalized understanding regarding the concern of not serving Resident #46 the correct portion size as noted on his/her meal ticket.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interviews, it was determined that the facility failed to provide evidence of educating, offering, and/or providing the pneumonia vaccine to residents. This was evident for one (Resident #9) out of five residents reviewed during the infection control task.The findings include:On 8/26/2025 at 11:08 AM, the surveyor conducted a record review of resident immunization records. The surveyor was unable to find evidence that Resident #9 had been offered, educated about, or received the pneumonia vaccine.On 8/26/2025 at 11:14 AM, the surveyor spoke with the Director of Nursing (DON) and requested evidence that Resident #9 had been educated and either received or declined the pneumonia vaccine.On 8/26/2025 at 12:12 PM, the surveyor again spoke with the DON, who stated they were unable to provide evidence that Resident #9 had received, or was educated about and declined, the pneumonia vaccine. The DON verbalized understanding that offering and educating is a regulatory requirement and stated it must have been missed because offering and educating is part of the admission process.