STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215260	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Number of residents sampled: Number of residents cited: Based on record review and interview, it was determined that the facility failed to ensure that a resident was free from abuse. This was evident for 1 (Incident #310745) of 3 Facility Reported Incidents (FRIs) reviewed during the annual survey.The findings include:On 08/11/2025 at 10:34 AM, review of Incident #310745 investigation documentation revealed that on 4/20/25, Geriatric Nursing Assistant (Staff #34) observed bruises on Resident #24's right ankle. Further review of the investigation documentation revealed when Staff #34 asked Resident #24 about the bruising, he/she indicated that GNA was rough and aggressive with him/her on 4/19/25. On 08/11/2025 at 10:43 AM, review of the follow-up investigation report form revealed that the allegation was verified by the facility based on statements collected and physical findings.On 08/13/2025 at 8:39 AM, the surveyor reviewed the concern with the Nursing Home Administrator, who was aware that the allegation was verified by the facility.

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
	215260	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Number of residents sampled: Number of residents cited: Based on record review and interview, it was determined that the facility failed to report an allegation of abuse within two hours. This was evident for 1 (Incident #310745) of 3 Facility Reported Incidents reviewed during the annual survey.The findings include:On 08/11/2025 at 10:34 AM, review of Incident #310745 investigation documentation revealed that on 4/20/25 at 11:30 AM, Geriatric Nursing Assistant (Staff #34) observed bruises on Resident #24's right ankle. Further review of the investigation documentation revealed that on 4/20/25 at 11:30 AM, when Staff #34 asked Resident #24 about the bruising, he/she indicated that GNA was rough and aggressive with him/her on 4/19/25. On 08/11/2025 at 10:43 AM, review of the investigation documentation revealed that the facility failed to report the incident to the Office of Health Care Quality until 4/20/2025 at 1:10 PM.On 8/11/25 at 11:28 AM, the surveyor reviewed the concern with the Nursing Home Administrator, she understood that the incident was not reported within two hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215260	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Number of residents sampled: Number of residents cited: Based on record reviews and interviews, it was determined that facility staff failed to ensure a thorough investigation was conducted for an allegation of staff to resident abuse and failed to maintain documentation. This deficient practice was evident for one resident (# 78) reviewed for facility reported investigations during the annual survey.The findings include:On 08/11/25, a review of the facility reported incident (FRI) # 310743 revealed that on 1/26/25, Resident #78 informed a nurse supervisor that a staff member made inappropriate comments while administrating medication on 01/24/25. The resident stated that the comments made them feel uncomfortable and embarrassed. A review of the facility's initial report form dated 01/27/25 indicated that the facility contacted the police. The alleged perpetrator was suspended, a psychiatric nurse practitioner was requested to evaluate the resident, and social worker met with the resident to ensure the resident felt safe. In addition, statements were obtained from Resident #78, the alleged perpetrator, the nurse supervisor, and staff who were working at the time of the alleged incident.A review of family nurse practitioner (NP) #37 progress note dated 01/28/25 indicated that NP #37 was requested to evaluate Resident #78 following an incident reported on 01/24/25. During the evaluation, the resident reported that a staff member exposed them, made inappropriate comments, and the incident made them feel embarrassed. NP #37 documented that that the resident's judgement and insight appeared intact. NP #37 concluded that, in her professional opinion after speaking with the resident, the allegations appear to be example of the resident's attention seeking behaviors and her fantasies about relationships. A review of the resident's medical record did not show documentation of a prior history of such behavior. A review of Resident #78's psychiatric evaluation and consultation dated 01/17/25, indicates that the resident was seen at the request of the facility for medication management. During the examination, the resident was noted as calm, well-groomed and cooperative. The resident's thought process was listed as linear, logical, and goal directed, with no acute psychiatric features observed. Further review of psychiatric evaluation from 09/17/24 through 01/17/25 did not reveal a history of attention seeking behavior. In addition, there was no documentation indicating that the resident was evaluated following the incident on 01/24/25.On 08/11/25, a review of the facility's follow-up investigation report form dated 01/30/25, indicated that the facility was unable to determine whether the incident actually occurred. The surveyor requested documentation to support the facility's conclusion, including evidence of the resident's behavioral concerns, documentation the resident was evaluated by psychology in relation to the incident from 01/24/25, and records verifying that the social worker met with the resident daily as indicated on the follow up investigation report form. During an interview with the Administrator (NHA), on 08/11/25 at 10:35 AM, the surveyor discussed the incident involving Resident #78 and asked about the basis of her conclusion regarding the incident. The NHA stated that her investigation was based on the nurse practitioners progress note. The surveyor explained that a review of Resident #78's care plan, progress notes, and psychiatric evaluations prior to the incident on 01/24/25 failed to reveal a history of attention seeking behavior, fantasies about relationships, or any other similar behaviors. The NHA acknowledged that she did not review the resident records and that her decision not to substantiate the incident was based on NP #37's progress note. On 08/11/25 at 11:06 AM, the Assistant Director of Nursing informed the surveyor that the facility was unable to provide the request

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215260	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215260	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with facility staff, it was determined that the facility failed to 1) initiate a care plan for residents receiving oxygen therapy, 2) initiate a care plan for a resident with Clostridioides difficile (C. Diff), and 3) initiate a care plan for a resident with colostomy. This was evident for 3 residents (Residents #19, #20 and #98) out of 3 resident records reviewed for care plans during the Medicare/Medicaid recertification survey. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider.Clostridioides difficile (C. Diff) is the currently accepted scientific name, replacing the former Clostridium difficile (C. Diff). Both names refer to the same bacterium, which is a common cause of diarrhea and colitis, particularly in individuals taking antibiotics. A colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the skin of the abdomen. A colostomy bag, also called a stoma bag or ostomy bag, is a small, waterproof pouch used to collect waste from the body. 1) On 08/04/2025 at 4:48 PM, during a review of Resident #19's electronic health record, it was noted that an order for oxygen therapy had been given on 07/27/2025. The surveyor reviewed the electronic care plans and found no care plan addressing oxygen therapy.At 5:11 PM on the same day, during an interview with the unit manager, Licensed Practical Nurse (LPN#5), when she was asked when Resident #19 had an order for oxygen therapy, she stated that the resident was placed on oxygen therapy on 07/27/2025. When asked who was responsible for initiating and updating care plans, she stated that the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and at times herself, were responsible for care plan initiation and updates. When asked whether Resident #19 had a care plan to reflect oxygen therapy and related interventions, she responded that she would consult with ADON.At 5:14 PM on the same day, during an interview with the ADON, when asked who was responsible for initiating and updating care plans, she stated that updating care plans was her responsibility, along with the DON and unit managers. When asked whether there was a care plan in place for the resident's oxygen therapy, she said she would check. After approximately five minutes, she confirmed that no care plan had been initiated for oxygen use. When asked if a care plan should have been in place for oxygen therapy, both the ADON and LPN #5 agreed that one should have been created.At 5:49 PM on the same day, when the DON was interviewed regarding the facility's expectations for updating care plans, he stated that care plans should be updated promptly whenever there is a change in a resident's condition. When he was informed of the absence of a care plan for Resident #19's oxygen therapy, the DON stated that the care plan was initiated after being notified by ADON that the surveyor could not find a care plan for Resident #19's oxygen therapy. 2) On 08/04/2025 at 11:11 AM, during the initial facility tour, the surveyor observed signage on Resident #20's door indicating Droplet and Contact Precautions. During a brief conversation, the resident referenced his/her health condition stating that he/she had loose stools.On 08/05/2025 at 11:21 AM, review of Resident #20's electronic health record showed the Progress notes dated 07/31/2025 indicated the resident was experiencing recurrent loose stools. The Medical Director was notified, a stool sample was ordered, and an antibiotic was initiated. laboratory results dated [DATE] confirmed Clostridium difficile (C. diff) infection. Progress notes from 08/04/2025 documented more than two loose stools within a 24-hour period. The note indicated Resident #20 receiving treatment for C. diff and the physician was aware.On 08/05/2025 at 11:50 AM, review of the care plan did not show that Resident #20 had any care plan that addressed the ongoing infection.On 08/05/2025 11:57 AM in an interview with Licensed Practical Nurse (LPN) #17 in the presence of the Unit Manager Staff #5, when she was asked about Resident #20's recent health condition, she stated that the resident had C. Diff infection. When asked for the facility's protocol for a resident with such infection, she stated that such resident would be placed on contact/isolation precautions to keep the infection contained. When asked about the care plan for the ongoing infection, she stated that she would check. However, after reviewing the care plan, she acknowledged that no interventions were documented for the infection and stated that a care plan should have been in place.At 12:09 PM the same day, the [NAME] President of Clinical Operations (Staff #16) joined the interview. When asked about facility expectations regarding care planning for an active infection, she confirmed that a care plan should have been developed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215260	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of a facility reported incident , record reviews and staff interviews, it was determined that the facility failed to 1) revise a care plan to accommodate the need after medication was increased and 2) revise a care plan after a facility reported incident. This was evident for 1 resident (Resident #69) out of 3 residents reviewed for care plans during the Medicare/Medicare recertification survey.The care plan provides an opportunity to see if it meets the residents' needs by reviewing what strategies are working and which are not. It can also identify changes in the resident's condition or behavior that will require revisions of the care plan. Care conferences are usually held on a regular basis, often quarterly, but can be scheduled more frequently if needed based on the resident's condition. 1) On 08/06/2025 at 9:57 AM, during a review of Resident #69’s order in his/her electronic health records, it revealed that the Medical Director, Staff #32 had given an order on 07/09/2025 for “Seroquel Tablet 25 MG (Quetiapine Fumarate) Give 1 tablet by mouth two times a day” to be given to the resident in addition to the initial order for Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) which was ordered on 04/05/2025. At 10:03 AM on the same day, review of Resident #69’s care plan did not show that it was revised to reflect the medication change. At 10:07 AM on the same day, a review of the resident’s progress notes in the electronic health record on 07/10/2025 showed “Alert Note with note text: Behaviors, Resident observed very agitated and aggressive towards staff and residents. MD made aware, medication in place”. On 08/06/2025 at 10:57 AM, in an interview with the Director of Nursing (DON), when he was asked for the protocol after a change in residents medication regimen regarding care plan updates, he stated that he would have expected the residents care plan to reflect the new change in the medication regimen with goals and intervention in place. When he was informed that Resident #69s care plan did not reflect the medication change, he confirmed that it was not updated and stated that he would update the care plan immediately. 2) On 08/07/2025 7:34 AM, the surveyor reviewed the facility’s reported investigation packet for intake 310746 which confirmed a verified altercation between Resident #69 and Resident #79. Both residents were documented as having dementia. At 7:48 AM on 08/07/2025, further review of the packet revealed a handwritten statement by Geriatric Nursing Assistant (GNA #39) in which she stated that “Resident #69 was entering and exiting every patient room bothering each patient”. At 10:25 AM on 08/07/2025, several progress notes in the electronic health records of Resident #69 noted that he/she gets agitated easily and gets redirected often. His/her care plan was also reviewed, and it was observed that the resident did not have any care plan in place for bothering other residents by going into their rooms and there was no care plan in place for his/her agitation behaviors as the only behavior care plan was for laying on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215260	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/2025 at 12:08 PM, in an interview with the Unit Manager Staff #5, while the Director of Nursing (DON) was present, she was asked about the resident’s behavior, she stated that the resident gets agitated, and wanders into residents’ rooms .When asked if the resident had a care plan in place for such behavior, she checked through the DON’s laptop and confirmed that Resident #69 did not have any care plan to address the behaviors. When she was asked what care plan she would have had in place for the resident, she stated that she would have included agitation and wandering into other resident’s rooms in the care plan update. At 12:12 PM on 08/07/2025, in an interview with the DON, he was asked about his expectations regarding updating a care plan after an incident, he stated that depending on the findings of the investigation, the care plan would be put in updated to reflect the incident, goals and intervention for the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215260	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of Complaint Number 310737, medical records, and interviews with facility staff, it was determined that the facility failed to ensure proper colostomy care was provided and documented for a resident (Resident #98), who had a colostomy. This deficiency was identified during the complaint investigation at the facility's Medicare/Medicaid recertification survey An ostomy is a surgery that makes a temporary or permanent opening in the skin called a stoma. A stoma is a pathway from an internal organ to the outside of your abdomen. A colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the skin of the abdomen. A colostomy bag, also called a stoma bag or ostomy bag, is a small, waterproof pouch used to collect waste from the body. The Minimum Data set (MDS) assessment is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. BIMS stands for Brief Interview for Mental Status. It is a standardized assessment tool used in long-term care facilities to screen residents for cognitive impairment. The BIMS assessment helps identify potential cognitive decline, including early signs of dementia and can help determine if further evaluation is needed. Findings include: On 08/11/2025 at 7:12 AM, review of complaint 310701 showed that on 01/23/2024, Resident #98 filed a complaint with the state agency stating that his/her colostomy bag had not been changed. A review of the resident's clinical records by the surveyor revealed that the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE]. MDS admission review on 01/03/2024 indicated that the resident had a BIMS score of 14 out of 15, signifying that he/she was cognitively intact at the time of the complaint. On 08/11/2025 at 7:28 AM, a further review of Resident#98’s medical records revealed the following. The resident had every other order but there was no order seen for the colostomy or the colostomy care. The admission notes on 12/26/2025 showed that Resident #98 The patient was admitted for wound care and rehabilitation, remained alert and oriented with full code status, verbal and in a pleasant mood, skin warm and dry, with a large unstageable sacral ulcer managed with wet-to-dry packing, skin tear under the right breast and abdominal folds due to moisture, bilateral edema, clear lungs with palpable pulses, a soft and non-tender abdomen, good appetite on a regular diet, and discharge orders were approved by the Medical Doctor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215260	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound notes on 12/27/2024 revealed that the patient presented with sacral and bilateral buttock wounds, status post chemoradiation, laparoscopic diverting sigmoid colostomy, and sacral debridement. On 08/11/2025 at 11:15 AM, review of the daily skilled nursing charts showed that the resident’s colostomy bag was changed on the following dates: 12/29/2023, 01/18/2024, 01/22/2024, 01/23/2024, 01/24/2024, 01/25/2024, 01/27/2024, 01/28/2024, 01/30/2024, and 02/22/2024. The last documented colostomy change was on 02/22/2024, which was also the last skilled nursing chart entry found in the resident’s electronic record. The resident was discharged from the facility on 03/20/2024, with no documentation available regarding colostomy bag changes between 02/22/2024 and discharge. On 08/11/2025 at 12:21 PM, during an interview with the Assistant Director of Nursing (ADON), when asked for the facility’s expectation regarding caring for a resident with a colostomy, she stated that the facility’s expectation for caring for a resident with a colostomy was that the colostomy bag should be emptied, cleaned, monitored, and changed as appropriate, with accurate documentation. When asked about physician involvement, she stated that attending physicians were contacted during admission and that charge nurses or unit managers were responsible for reviewing admissions with physicians and obtaining orders for residents with colostomies. When informed that the resident did not have an order for colostomy care, the ADON acknowledged that there should have been a physician order specifying colostomy care, including change times, and appropriate interventions. On 08/11/2025 at 1:15 PM, when the Director of Nursing (DON) was informed about the concerns with Resident #98’s colostomy care, he stated that there should have been a physician order to monitor the site and color of the ostomy, the fecal output, the frequency of colostomy bag changes, and the size of the bag, along with a care plan specifying nursing interventions for colostomy care. When asked about his expectations for skilled nursing charting, he stated he would have expected daily documentation while the resident was under skilled services. He further explained that after the skilled days ended, the order for colostomy care should have been placed on the Treatment Administration Record (TAR) and documented as appropriate. When asked how often the colostomy bag should be changed, he stated it should be changed weekly or as needed (PRN) if soiled.