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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Number of residents sampled: Number of residents cited: Based on observation and interview, it was determined that the facility failed to ensure that resident rights are maintained by knocking prior to entering a resident's room. This was evident for 2 of 2 observations on the Chesapeake unit upon facility initial entry.The findings include:On 08/04/2025 at 9:12 AM, during an interview with Resident #8, Registered Nurse (Staff #11) opened the door and walked into the room but failed to knock prior to entering. On 08/04/2025 at 9:21 AM, an observation right outside of Resident #8's room revealed Staff #11 walked into the residents room without knocking.On 08/04/2025 at 4:50 PM, an interview with the Director of Nursing revealed that the expectation was for staff to knock prior to entering a resident's room. The surveyor reviewed the concern.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Number of residents sampled: Number of residents cited: Based on interview and record review, it was determined that the facility failed to ensure that Advanced Beneficiary Notice of Noncoverage (ABN) was provided as required. This was evident for 1 (Resident #99) of 3 residents reviewed for beneficiary notification.The findings include:The ABN notice is provided to residents/responsible parties in order to provide information so the resident/responsible party can make a decision to continue to receive services that may not be paid for by Medicare and assume the financial responsibility prior to services ending.On 08/11/2025 at 9:07 AM, the surveyor requested Resident #99's beneficiary notification documentation for review.On 08/11/2025 at 11:15 AM, Business Office Manager (Staff #4) provided the documentation for Resident #99's beneficiary notification which indicated the last day covered for Part A Services was 2/4/25. Staff #4 informed the surveyor that she was unable to find documentation regarding the ABN. At the same time, an interview with Staff #4 revealed that Resident #99 was unable to sign so the representative would have been contacted regarding the ABN by phone or mail. The surveyor asked what the expectation was for documentation when a representative was contacted for the ABN, she indicated she was unaware of the process.On 08/11/2025 at 1:22 PM, the surveyor reviewed the concern with the Director of Nursing. He indicated that there should have been some documentation if a phone call was made or if the letter was sent out to the resident's representative.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Number of residents sampled: Number of residents cited: Based on observation and interview, it was determined that the facility failed to ensure residents had a homelike dining environment. This was evident for the initial dining observation during the annual survey.The findings include:On 08/04/2025 at 9:35 AM, an initial observation of the Chesapeake unit upon facility entrance revealed the dining room was locked and unused for breakfast. The residents were getting their breakfast delivered to their rooms.On 08/11/2025 at 2:35 PM, an interview with the Nursing Home Administrator (NHA) revealed that the dining room was locked for breakfast and dinner. She said the residents were not up and ready in the morning by breakfast time so it stayed locked until lunch, and was locked again for dinner. The surveyor reviewed the concern.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Number of residents sampled: Number of residents cited: Based on record review and staff interviews, the facility failed to ensure less restrictive alternatives were attempted and documented prior to administering an additional antipsychotic medication. This deficient practice was evident for 2 (Resident #6 and #69) of 2 residents reviewed for unnecessary medications during a Medicare/Medicaid recertification survey. The findings include: 1) On 08/06/2025 at 10:03 AM, a record review revealed that on 07/09/2025, the Medical Director (Staff #32) ordered an additional prescription of Seroquel (Quetiapine) 25 mg BID, in addition to the standing Quetiapine 50 mg BID, increasing the total daily dose to 75 mg at 9:00 AM and 5:00 PM. On 08/06/2025 at 10:07 AM on the same day, a review of Resident #69'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. Medical Doctor made aware, medication in place. The note did not reflect whether non-pharmacological interventions were attempted prior to the medication increase. On 08/06/2025 at 10:50 AM, in an interview with the Director of Nursing (DON), when he was asked for the non-pharmacological intervention given to Resident #69 on 07/09/2025 when an agitation behavior was observed, he stated that there was none. On 08/07/2025 at 10:57 AM, in a phone interview with the Medical Director (Staff #32), he acknowledged that he ordered Seroquel (Quetiapine) 25 mg on 07/09/2025 due to Resident #69's agitation but failed to document the rationale and did not order non-pharmacological intervention. The Medical Director stated, It was an error from me; I should have documented the reason for the increase and ordered non-pharmacological interventions to resident #69's treatment order. 2) Gradual Dose Reduction (GDR) refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. On 08/05/25 at 12:37 PM, a review of Resident # 6's medical records revealed that the monthly medication regimen reviews conducted between 08/12/24 and 07/16/25, and an irregularity was identified on 09/15/24. The surveyor requested to review the irregularity and the pharmacist's recommendation to the physician. Review of the pharmacist's recommendation dated 09/15/24 revealed that Resident #6 was prescribed Seroquel (Quetiapine) 50 milligram (mg), Lexapro (Escitalopram) 20 mg, and Haldol (Haloperidol) 2mg. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pharmacist recommendation note: please indicate if these medications are eligible for a gradual dose reduction (GDR) while concurrently monitoring for the emergence of depressive and/or withdrawal symptoms. Further review of the medical record showed that the Lexapro dosage was not addressed until 03/28/25. The Haldol dosage was not adjusted until 06/20/25, and Seroquel dosage was not adjusted until 06/06/25. During an interview with the Director of Nursing (DON) on 08/05/25 at 1:06 PM, the DON acknowledged that monthly pharmacy reviews were completed for Resident #6 and that irregularities for Seroquel, Lexapro, and Haldol were identified on 09/15/24. When asked if the facility provided the resident with non-pharmacological interventions, the DON stated that he believed interventions were provided but was unable to provide documentation.

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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.

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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** Number of residents sampled: Number of residents cited: Based on record reviews and interviews, it was determined that facility staff failed to ensure electronic transfer forms and bed hold notices were completed in Point Click Care for a resident who was transferred to the hospital. This deficient practice was evident for one resident (#93) reviewed for transfer notices during the annual survey.The findings include: On 08/07/2025 12:07 PM, during a review of Resident #93's medical record, the surveyor noted documentation indicating that the resident was transferred to the hospital on 4/24/25. The surveyor confirmed that the facility had completed an electronic transfer form and bed hold notice. Further review showed another transfer to the hospital on [DATE], in which there was no documentation indicating that an electronic transfer form or bed hold notice had been completed. The surveyor requested proof of an electronic transfer form and bed hold notice completed. During an interview with the Director of Nursing (DON) on 08/07/25 at 12:43 PM, when asked about the process for completing transfer notices and bed hold forms for hospital transfers. The DON stated, generally transfer forms and bed hold notices are completed at the time of transfer in Point Click Care using the electronic interact transfer form. The DON further explained that exceptions may occur when transfers happened on the weekend or holidays, however, the notice should still be submitted as soon as possible. On 08/07/25 at 1:10 PM, the Regional Policy Nurse #21 informed the surveyor that the nurse assigned to Resident #93 failed to complete the electronic interact transfer form and bed hold notice for the resident's hospital transfer on 05/09/25.On 08/07/2025 at 1:19 PM, during an interview with the DON concerning the missed transfer form bed hold notice on 05/09/25, the DON stated that the process is a collaborative approach; however, the nurse sending the resident to the hospital is responsible for ensuring that the transfer form and bed hold notice are completed in Point Click Care (electronic medical record).

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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. Number of residents sampled: Number of residents cited: Based on record review and interview, it was determined that the facility failed to ensure the Minimum Data Sheet (MDS) accurately reflected a resident's status. This was evident for 1 (Resident #5) of 3 residents reviewed for pressure ulcers/wounds.The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need.On 08/04/2025 at 5:13 PM review of Resident #5's medical record revealed a documented skin check dated 4/23/25 that indicated the resident had four wounds. At the same time, further review of the skin check document revealed two of the wounds (the left hip and right heel) were documented as present on admission (the resident had the wounds prior to being admitted to the facility).On 08/04/2025 at 5:19 PM, review of Resident #5's medical record revealed section M of an MDS with an Assessment Reference Date (ARD) of 4/22/25, which indicated all four wounds, including the left hip and right heel were not present on admission. The surveyor then requested a copy from the facility.The Assessment Reference Date (ARD) is the specific end point of look-back periods of resident status for the MDS assessment process.On 08/06/2025 at 12:14 PM, Regional MDS Coordinator (Staff #15) provided a copy of the MDS that the surveyor requested, indicated she was aware of the error, and that she revised the MDS error after the surveyor's intervention. Further interview revealed the left hip and right heel should have been marked as present upon admission on the MDS to accurately reflect the resident's status.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and interviews, it was determined that facility staff failed to provide evidence that a level 1 preadmission screening and resident review (PASARR) was completed prior to admission, or at the time of admission for a resident with a mental disability. This deficient practice was evident for 1 (Resident #6) of 2 residents reviewed for PASARR during the annual survey. The findings include: The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders, intellectual disabilities and related conditions. This initial screening is referred to as Level I Identification of individuals with MD or ID and is completed prior to admission to a nursing facility. The purpose of the Level I pre-admission screening is to identify individuals who have or may have MD/ID or a related condition, who would then require PASARR Level II evaluation and determination prior to admission to the facility. During a medical record review for Resident #6 on 08/04/25, it was revealed that the resident was admitted to the facility on [DATE] with multiple diagnoses including paranoid schizophrenia. Further review of the resident's paper chart and electronic medical records failed to show a PASARR had been completed prior or at the time of admission. The surveyor requested documentation showing that a PASARR was completed On 08/05/2025 at 8:00 AM, the Social Worker Assistant (SW) #8 provided the surveyor with Resident #6's PASARR dated 09/16/21. The surveyor informed the SW #8 that the resident had been admitted on [DATE] and again requested the PASARR from 10/28/19. The SW #8 explained that she was not working as a social worker at the time and was unable to local the resident's PASARR from 2019. Review of Resident #6's medical records on 08/05/25 at 11:51 AM, revealed the Regional Social Worker (SW) #9 completed a level 1 PASRR through the electronic platform named Telligen. On 08/06/25 at 8:44 AM, SW #8 provided the surveyor with a copy of the completed level 1 PASRR.

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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)

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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

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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)

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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.

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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 staff failed to follow physician's orders and professional standards of quality when administering blood pressure medication. This deficient practice was evident for one resident (#9) reviewed for professional standards during the annual survey. The findings include: On 08/05/25 at 4:51 PM, a review of Resident #9's medication administration record (MAR) for July 2025 revealed a physician's order dated 12/31/24 for Metoprolol 25 milligram (mg) to be administered twice daily for hypertension with instruction to hold the medication if the systolic blood pressure was less than 100 mmHg. The MAR showed that the Metoprolol was administered twice daily for the entire month of July 2025. However, review of the resident's blood pressure readings revealed that it was only recorded on 7/3/25, 7/8/25, 7/16/25, and 7/21/25. On 8/6/25 at 10:45 AM, during an interview with licensed practical nurse (LPN) #5, the survey asked about the process for administering blood pressure medications. The LPN #5 explained that in general residents were ordered for monthly blood pressure checks. She then stated that for residents with blood pressure parameters, she obtains the blood pressure prior to administering the medication. When asked if blood pressures were documented in the system, the LPN #5 confirmed that they were. On 08/06/25 at 11:00 AM, the surveyor discussed Resident #9's blood pressure medication and the lack of documented blood pressure readings in the medical records with the Director of Nursing (DON). The surveyor asked if he could review the resident's medical record for any blood pressure readings the surveyor may have overlooked. The DON stated that if the blood pressure was not documented in the system, it was most likely not done.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Number of residents sampled: Number of residents cited: Based on interviews and record reviews, it was determined that the facility staff failed to provide appropriate treatment to maintain the resident's ability to perform activities of daily living. This deficient practice was evident for 1 (Resident #6) of 2 residents reviewed for vision and hearing. The findings include: During an interview with Resident #6 on 08/04/2025 at 10:56 AM, the resident expressed concerns about their vision and hearing and stated that the facility did not address the concerns. A review of Resident #6's medical records revealed that the facility referred the resident to 360 Care for an ear exam due to decreased hearing. The exam was completed on 07/08/25. The audiologist documented that the resident's exam was abnormal due to impacted cerumen (earwax) and recommended Debrox (earwax removal aid) for the resident's left ear. Review of the resident's physician orders failed to show an order for Debrox or documentation explaining why the recommendation was not followed. On 08/05/25 at 9:43 AM, during an interview with the Assistant Director of Nursing (ADON), the surveyor asked about the facility's process for addressing provider consult recommendations. The ADON explained that all recommendations were completed by nursing staff, who first contact the doctor for a verbal order. The nurse would enter the order in the resident electronic medical record. The surveyor informed the ADON of the audiologist recommendation from 07/08/25 and requested proof that the recommendation had been addressed. On 08/05/25 at 10:46 AM, the ADON provided the surveyor with a new order for Debrox dated 8/5/25. When asked why the order was not completed on 7/8/25, the ADON stated that the staff responsible for the resident failed to place the order at that time.

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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. Number of residents sampled: Number of residents cited: Based on interviews and record reviews it was determined that facility staff failed to assist a resident who was dependent on staff for activities of daily living (ADLs) for showers. This deficient practice was evident for 1 (#38) resident reviewed for ADL care during the annual survey. The findings include: During an interview with Resident #38 on 08/04/25 at 11:20 AM, the resident stated they are to receive showers on Wednesday and Saturday during the evening shift. However, staff fail to provide showers and instead offered a bed bath. The resident stated they would prefer showers and reports that staff sometimes document that they refused showers, which the resident stated was not true. On 08/04/25 at 11:30 AM, during an interview with the Unit Manager #7 (UM), the surveyor asked where staff documented residents showers. The UM #7 stated that some staff documented showers in Point Click Care (PCC), and other staff recorded them in the unit's shower log. The surveyor reviewed the shower logbook which revealed that Resident #38 shower days were Wednesday and Saturday. The review also revealed documentation indicating that the resident received a shower on July 9 and July 16, 2025. No additional shower dates were recorded. On 08/07/25 at 11:41 AM, the surveyor requested ADL shower days from PCC for Resident #38 during the months of May, June, and July 2025. On 08/07/25 at 4:14 PM, the surveyor reviewed documentation of ADL-shower days for the months of May, June, and July 2025, which revealed that showers were documented as given on the following days: Saturday May 3 shower evening shift Saturday June 14 shower evening shift Saturday June 21 shower evening shift Saturday June 28 shower evening shift Wednesday July 3 shower evening shift Wednesday July 9 shower evening shift Wednesday July 16 shower evening shift Wednesday July 23 shower evening shift Saturday July 26 shower evening shift (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/11/25 at 09:05 AM, during an interview with the Assistant Director of Nursing (ADON) the surveyor discussed Resident #38's concerns, the shower log, PCC shower day documentation, and lack of documentation explaining why the resident did not receive a shower. The ADON stated that staff were expected to provide showers to residents and should not substitute a bed bath in place of a shower. The ADON also stated, when a resident refuses a shower, staff were expected to document the refusal in the medical records.

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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** Number of residents sampled: Number of residents cited: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews, observations, and record reviews it was determined that staff failed to 1.) adequately monitor and assess urinary output and 2.) ensure pain was assessed and managed per the physician's order. This deficient practice was evident for one Resident (#38) reviewed for quality of care and one (#94) of two residents reviewed for pain management during the annual survey.The findings include: 1. On 08/04/2025 at 11:20 AM during an interview, Resident #38 reported that the urine in their foley catheter bag was often dark, bloody with clots and staff fail to irrigate the foley catheter tubing. The resident further stated they were hospitalized in April 2025 for urinary tract infection since staff failed to irrigate the foley catheter tubing. The surveyor observed amber colored cloudy urine in the resident's foley catheter bag. On 08/06/25, a review of Resident #38 medical record revealed a progress note dated 04/27/25 at 10:28 PM, documented by Registered Nurse (RN) #36, which indicated the resident's foley catheter was changed due to blockage and leakage. There was no documentation indicating the doctor was notified of the blockage and leakage, nor was there documentation of urinary monitoring or assessment. A progress note dated 04/28/25 at 11:59 AM, documented by licensed practical nurse (LPN) #35 indicated that Resident #38 urinary tubing and drainage bag contained blood and clots. The Nurse Practitioner (NP) #37 was notified and recommended obtaining a urinalysis (UA) and lab work. A review of the resident's medical records revealed that the UA was not collected, and there was no documentation of ongoing urinary monitoring or assessment.A progress note dated 04/28/25 at 10:04 PM, documented by RN #36, indicates the resident continued to have large amounts of hematuria (bloody urine) present in the foley catheter bag and was noted to be excessively drowsy, confused, with incoherent speech, and unable to follow commands. The NP #37 was notified, and the resident was transferred to the hospital. The Assistant Director of Nursing contacted the hospital for an update; it was reported that the resident was diagnosed with a urinary tract infection and admitted to the hospital on [DATE]. Further review of Resident #38's medical record on 08/06/25, revealed a progress note dated 08/05/25, documented NP #42, indicating the resident was lethargic, diaphoretic and foley catheter in place with yellow cloudy urine in the bag. The resident was transferred to the hospital on [DATE] and admitted for sepsis, urinary tract infection, acute kidney injury and diabetic ketoacidosis. Review of the medical record failed to show evidence that staff were assessing and monitoring urinary output. On 08/08/2025 at 12:07 PM, during an interview with Medical Doctor (MD) #41, the surveyor discussed the lack of urinary output, assessment, and monitoring for Resident #38 prior to both hospital admissions. The physician stated that he expects staff to provide foley catheter care, assess urinary output, and report any changes. He further stated that he would have expected staff to notify him of any observed changes or concerns for Resident #38During an interview with LPN #35, on 08/11/2025 at 2:47 PM, she stated that Resident #38 often has issues with the color of their urine. When asked who was responsible for collecting the urine specimen for the residents UA on 04/28/25, the LPN #35 acknowledged that she was responsible, but did not know why she failed to collect it. During a phone interview with RN #36 on 8/11/25 at 2:52 PM, he stated that he does not always assess resident's urine in the foley catheter bag. When asked how he identifies changes in a resident's urine, he reported that the geriatric nursing assistant informed him of urinary output. The surveyor informed him of the cloudy urine observed in Resident #38 foley catheter bag on 8/4/25. The RN acknowledged that he failed to assess the resident's urinary output on 08/03/25 and 08/04/25.2. Review of Resident #94's medical records on 08/07/25 revealed the resident was admitted to the facility on [DATE], with multiple medical diagnoses, including liver cell carcinoma. A pain evaluation completed on 05/03/25 indicated that during the past five days the resident frequently experienced pain that impacted their sleep at night. The resident reported moderate generalized pain with a pain rating of 5 out of 10. The evaluation further noted that non-medication interventions did not provide pain relief. Review of Resident #94's treatment administration record dated 05/04/25 revealed a physician's order for a pain evaluation every shift. Documentation showed a pain evaluation was completed on 05/04/25, during day and night shift, and again on 05/05/25 during the day, evening, and night shift. The next documented pain assessment was not until 05/14/25 during the day shift. There was no documentation explaining why the resident's pain was not assessed between 05/06/25 to 05/13/25. Review of Resident #94's medication administration record revealed a physician's order dated 05/05/25, for morphine 0.25 milligram (ml) by mouth every 1 hour as needed for shortness of breath and comfort care, with instruction for staff to document a progress note for all non-pharmacologic interventions made. The documentation showed morphine was

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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. Number of residents sampled: Number of residents cited: Based on interview and record review, it was determined that the facility failed to ensure a resident received services consistent with professional standards of practice to prevent new pressure ulcers/wounds from developing. This was evident for 1 (Resident #5) of 3 residents reviewed for pressure ulcers/wounds.The findings include:On 08/04/2025 at 8:20 AM, an interview with Resident #5 revealed that the facility staff did not always turn him/her from side to side every two hours, and as a result, he/she developed two new pressure ulcers/wounds in the facility. He/she further indicated he/she was unable to reposition himself/herself and was dependent on staff for repositioning. On 08/04/2025 at 5:07 PM, a review of Resident #5's medical record revealed a resident assessment with an ARD dated of 2/21/25 that indicated the resident had a Brief Interview for Mental Status (BIMS) of 15. A recent resident assessment with an ARD of 8/6/25 indicated the resident had a BIMS of 14.A Brief Interview for Mental Status (BIMS) is a tool used to screen and identify the cognitive condition of residents in a long-term care facility. The BIMS assessment uses a points system that ranges from 0 to 15 points. A BIMS score of 13-15 indicates the resident's cognition is intact.The Assessment Reference Date (ARD) is the specific end point of look-back periods of resident status for the assessment process.On 08/04/2025 at 5:13 PM, further review of Resident #5's medical record revealed he/she had two wounds upon admission and was being seen by the Wound Nurse Practitioner (Staff #43). Further record review revealed a wound note dated 2/19/25 that indicated preventative measures recommended were turning/repositioning precautions per protocol.At the same time, review of Resident #5's record revealed an order for a low air loss mattress.On 08/04/2025 at 5:18 PM, review of Resident #5's medical record revealed a skin check dated 3/19/25 which indicated the resident had a sacral (bone area above the buttocks) wound that was acquired in the facility first identified on 3/18/25. On 08/04/2025 at 5:26 PM, further review of Resident #5's medical record revealed two documents titled, Documentation Survey Report v2, for February and March 2025. The documents revealed documentation of the Resident being turned/repositioned which was listed by hours within a twenty-four hour period. Documentation revealed that the resident failed to be turned during the following times on the listed dates :Between 4:00 PM and 10:00 PM on 2/26/25Between 12:00 AM and 8:00 AM & 4:00 PM and 10:00 PM on 2/27/25 Between 8:00 AM and 2:00 PM on 2/28/25Between 4:00 PM and 10:00 PM on 3/2/25Between 6:00 PM and 10:00 PM on 3/3/25Between 4:00 PM and 10:00 PM on 3/5/25Between 12:00 AM and 3:00 AM & 4:00 AM and 8:00 AM on 3/6/25Between 4:00 PM and 10:00 PM on 3/7/25 Between 8:00 AM and 10:00 PM on 3/11/25Between 8:00 AM and 4:00 PM on 3/15/25Between 12:00 and 3:00 AM, 4:00 AM and 8:00 AM, & 4:00 PM and 10:00 PM on 3/18/25On 08/11/2025 at 12:48 PM, a follow up interview with Resident #5 revealed that an unidentifiable staff member informed him/her that day to remind them to turn him/her every two hours if they forgot.On 08/11/2025 at 12:57 PM, a review of the facility policy titled, Turning and Repositioning, with a date of 11/13/24, revealed that if a resident was unable to reposition themselves, that the facility would turn them every hour.On 08/11/2025 at 1:44 PM, a phone interview with Wound Nurse Practitioner (Staff #44) revealed that turning residents per protocol is initiated for residents to help improve current and/or prevent new wounds. She further indicated that a low air loss mattress was used along with turning and repositioning for residents. She indicated that one (an air loss mattress or turning and repositioning) does not negate (eliminate the need) for the other to also be implemented.On 08/11/2025 at 2:35 PM, the surveyor reviewed the concern with the Director of Nursing.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on surveyor observation, review of the medical record, and interview with facility staff, it was determined the facility staff failed to provide residents with respiratory care consistent with professional standards by 1) failing to date and label the oxygen tubing, nasal cannula and the humidifier bottle and 2) failing to follow the physicians' order for the oxygen administration. This was evident for 1 resident (Resident #19) out of 1 resident observed on oxygen therapy during the Medicare/Medicaid recertification survey.The findings include: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. Oxygen saturation or SpO , is a medical measurement that indicates the percentage of oxygen-carrying hemoglobin in the blood compared to the total amount of hemoglobin. It is a key indicator of how well oxygen is being distributed from the lungs to the rest of the body.Oxygen tubing is a clear, flexible, medical-grade tube used to deliver oxygen from a source (like an oxygen concentrator or cylinder) to a patient, typically through a nasal cannula or oxygen mask. It acts as a conduit, ensuring a continuous flow of oxygen to the patient. LPM is Liters Per Minute (in the context of oxygen therapy)A nasal cannula (NC) is a thin, flexible tube used to deliver oxygen or other gases directly into the nostrils. It consists of two prongs that are inserted into the nose, with a tubing that extends behind the ears and under the chin.A humidifier bottle, in the context of oxygen therapy, is a disposable container used to add moisture to dry oxygen delivered to a patient. It helps prevent dryness and irritation of the respiratory tract, making oxygen therapy more comfortable. These bottles are typically translucent, allowing for easy monitoring of the water level. 1) On 08/04/2025 at 8:31 AM, during the initial tour of the units, Resident #19 was observed in bed with a nasal cannula and oxygen running at approximately 2.25 liters per minute. It was noted that the oxygen tubing, nasal cannula, and humidifier bottle were not labeled or dated.At 8:34 AM on the same day, the unit manager, Licensed Practical Nurse (LPN) #5, was called for dual observation and confirmed that the oxygen tubing, nasal cannula, and humidifier bottle were not labeled or dated. When asked when the equipment was changed and how frequently it should be changed, the nurse stated that she did not know the last time it was changed, but it should be changed weekly. When asked whether it should have been labeled and dated, she affirmed that it should have been and stated she would change and properly label/date the equipment immediately.At 10:51 AM on the same day, the concern regarding the labeling and dating of the oxygen delivery equipment was discussed with the Director of Nursing (DON). When asked about the facility's expectations, the DON stated that equipment should be labeled and dated immediately after being changed, and such changes are expected to occur weekly.2) On 08/04/2025 at 8:37 AM when LPN #5 was asked how many liters of oxygen were prescribed for Resident #19, she stated the resident was prescribed 2 liters per minute (2 LPM). Upon verification by LPN #5, she informed the surveyor that the oxygen flow rate was found to be approximately 2. 25 liters per minute. When asked if there was a clinical indication for the increased flow, she stated that there was none, as the resident was stable on 2 LPM. The nurse then adjusted the oxygen flow rate to 2 LPM. When asked how often oxygen flow rates should be checked, she responded, every shift. When LPN #5 was asked for the most recent oxygen saturation for Resident #19, she stated that the most recent oxygen saturation (SpO) level recorded for the resident was 99% on 08/01/2025.At 4:48 PM on 08/04/2025, a review of the resident's electronic health record revealed an active order for: Oxygen via nasal cannula (NC) at 2 LPM to maintain SpO >92%; titrate up to 6 LPM via NC as needed to maintain SpO >92%. The most recent oxygen saturation documented was 99% on 08/01/2025.At 5:39 PM on 08/04/2025, the DON was asked about the facility's expectation for oxygen flow rate management. He stated that the flow rate should align with the physician's order. Upon being informed of the earlier discrepancy in the resident's oxygen flow rate, the DON stated that he would verify the current flow and ensure it matched the prescribed order. At 5:48 PM on 08/04/2025, the DON informed the surveyor that the nurse had already adjusted the oxygen flow rate accordingly.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, it was determined that the facility failed to ensure 1) pain management was provided to a resident based on professional standards of practice and the comprehensive person-centered care plan, and 2) adequate pain management by assessing pain as ordered. This was evident for 2 (Resident #8 and #94) of 2 residents reviewed for pain management. The findings include: 1) On 08/04/2025 at 9:17 AM, an interview with Resident #8 revealed that he/she was always in pain due to his/her back, and that his/her pain was not managed by his/her current medication regimen. On 08/04/25 at 4:56 PM, review of Resident #8's medical record revealed a progress note titled, nurse practitioner follow up note, dated 7/30/25 at 10:30 PM by Nurse Practitioner (Staff #40), which indicated the resident reported he/she had low back pain all of the time due to arthritis. At the same time, further review of the resident's medical record failed to reveal that Staff #40 addressed the pain that was reported by the resident. On 08/04/25 at 5:01 PM, review of Resident #8's comprehensive care plan revealed a focus of pain management related to chronic (extended period of time) pain, with a goal for the resident to be free from discomfort. On 08/04/25 at 5:04 PM, further review of the resident's medical record revealed the resident had an active medical diagnosis of pain. On 08/06/25 at 2:30 PM, an interview with the Medical Director revealed that upon reviewing the residents record after surveyor intervention, he was aware of the nurse practitioner's progress note dated 7/30/25 that indicated the resident was always in pain. He further indicated that the expectation was for staff to address pain and that Staff #40 should have addressed the resident's pain when he/she reported it. On 08/12/25 at 9:03 AM, review of Resident #8's medical record revealed that the resident was ordered a new pain medication regimen after surveyor intervention. 2) Review of Resident #94's medical records on 08/07/25 revealed the resident was admitted to the facility on [DATE], with multiple medical diagnoses, including liver cell carcinoma. A pain evaluation completed on 05/03/25, indicated that during the past five days the resident frequently experienced pain that impacted their sleep at night. The resident reported moderate generalized pain with a pain rating of 5 out of 10. The evaluation further noted that non-medication interventions did not provide pain relief. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/25 the surveyor reviewed a progress note dated 05/14/25 at 1:14 PM, documented by Nurse Practitioner (NP) #37 that the resident was uncomfortable, verbally upset and expressed that staff were not taking care of them. Staff reported that the resident refused care and appeared agitated, so they left the resident alone. Staff further stated they were afraid to enter the resident's room due to the resident's agitation. The progress note documented that the resident was on comfort care with orders for morphine for pain and Ativan for agitation; however, staff did not administer the medications as ordered. The NP #37 instructed staff that the resident needs to be given pain medication and Ativan when agitated. Review of Resident #94's treatment administration record dated 05/04/25 revealed a physician's order for a pain evaluation every shift. Documentation showed a pain evaluation was completed on 05/04/25, during day and night shift, and again on 05/05/25 during the day, evening, and night shift. The next documented pain assessment was not until 05/14/25 during the day shift. There was no documentation explaining why the resident's pain was not assessed between 05/06/25 to 05/13/25. Review of Resident #94's medication administration record revealed a physician's order dated 05/05/25, for morphine 0.25 milligram (ml) by mouth every 1 hour as needed for shortness of breath and comfort care, with instruction for staff to document a progress note for all non-pharmacologic interventions made. The documentation showed morphine was administered once on 05/7/25 and 05/10/25-05/15/25. On 08/08/25 at 10:47 AM, during an interview with Unit Manager (UM) #7, the surveyor discussed Resident #94 and asked why the resident's pain was not assessed every shift as ordered and why morphine was not administered PRN (as needed) per the order. The UM#7 stated that she had cared for the resident once, and during that time she assessed pain and administered morphine once but acknowledged that she did not document ongoing pain assessments. On 08/08/2025 11:36 AM, the surveyor discussed Resident #94's admission with pain, the nurse practitioner's progress note, the lack of documented pain assessments, and the failure to administer PRN morphine as ordered. The DON acknowledged the findings.

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Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, it was determined that the facility failed to ensure that the physician reviewed a resident's total plan of care at each visit. This was evident for 1 (Resident #8) of 2 residents reviewed for hospitalization during the annual survey.The findings include:On 08/04/2025 at 9:17 AM, an interview with Resident #8 revealed that he/she was always in pain from his/her back. He/she indicated their pain was not managed by their current medication regimen.On 08/04/25 at 4:37 PM, review of Resident #8's medical record revealed that he/she was hospitalized on [DATE].On 08/04/25 at 4:46 PM, further review of Resident #8's medical record revealed the discharged summary from the hospital dated 7/29/25, which indicated that the resident had been seen by palliative medicine. Further review of the discharge summary revealed that the resident had back pain and that the resident was recommended by palliative medicine to have transdermal (medication route by skin) fentanyl (strong, controlled pain medication) patch for the back pain.On 08/04/25 at 4:53 PM, review of Resident #8's medical record revealed a physician follow up note (first since readmission from the hospital) dated 7/31/25 by Attending Physician (Staff #41). Staff #41 indicated the resident's recent hospital stay, but failed to address the fentanyl patch recommendation for Resident #8's back pain from the hospitalization on 7/25/25.On 08/05/25 at 9:38 AM, an interview with Attending Physician (Staff #41) revealed that the expectation was for the physician to review a resident's total plan of care when readmitted to the facility including the discharge summary. He further indicated the expectation was to address instructions and recommendations from the hospital as well as medications to make sure everything was reasonable. He then indicated that sometimes, the physician would miss some changes or sections in the discharge summary, but it was not typically the case.08/06/25 at 11:24 AM, the surveyor made a phone call to the Medical Director and reviewed the concern. He informed the surveyor that he would look into it and follow up with the surveyor.On 08/06/25 at 2:30 PM, a follow up phone interview with the Medical Director revealed that the physicians were expected to review a resident's total plan of care when readmitted to the facility which would include reviewing the discharge summary and addressing the recommendations. During the same interview, the Medical Director indicated to the surveyor that he agreed the physician lacked sufficiency in addressing the fentanyl patch recommendation from the discharge summary. He further indicated that the facility failed to catch the fentanyl patch recommendation from the discharge summary.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Number of residents sampled: Number of residents cited: Based on interview and record reviews, it was determined that facility staff failed to ensure sufficient weekend staffing. This deficient practice was evidenced by the Payroll-Based Journal (PBJ) report review during the annual survey.The findings include:A review of the facility's Payroll-Based Journal (PBJ) report on 07/30/25, revealed that the facility was flagged for excessively low weekend staffing levels during the second quarter of 2025. On 08/12/25 at 8:09 AM, a review of the facility assessment showed that the document was updated in 2025. Further review indicated that, to provide continuity of care for residents, the facility's staffing goal is 3.15 Hours Per Patient per Day (HPPD). On 08/12/25 at 8:36 AM, during an interview with Staffing Coordinator (SC) #6, the surveyor discussed that the facility's PBJ report indicated low weekend staffing. The SC #6 acknowledged that the facility had low staffing on the weekends through June 2025. When asked whether the facility uses agency nursing staff, the SC #6 stated that the facility had been agency free since April 2024. When asked what steps the facility would take to ensure proper staffing, the SC #6 reported that the facility would contact its sister facility to request staff support. She explained that in June 2025 the facility hired additional staff specifically to cover the weekend shift and since that time, the facility has not experienced issues with weekend staffing. The surveyor requested to review the HPPD data for March, April and May 2025. A review of the HPPD indicates the following:March 2025: 03/01/25- 2.57, 03/02/25-2.75, 03/08/25-2.41, 03/09/25- 2.51,03/15/25-2/75, 03/16/25-2.77, 03/29/25-2.67, 03/30/25, 2.7. The facility failed to meet staffing requirements 4 out of 5 weekends in March.April 2025: 04/05/25-2.95, 04/06/25-2.87, 04/12/25-2.92, 04/13/25-2.96, 04/19/25-2.7, 04/20/25-2.85, 04/27/25-2.97. The facility failed to meet staffing requirements 4 out of 4 weekends in April.May 2025: 05/03/25-2.89, 05/04/25-2.97, 05/10/25-2.59, 05/11/25-2.57. The facility failed to meet staffing requirement 2 out of 5 weekends in May. The Administrator and Director of Nursing were made aware of the second quarter 2025 PBJ report and were provided with a copy of the report during the entrance conference on 08/04/25.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Number of residents sampled: Number of residents cited: Based on interviews and record reviews, it was determined that the facility staff failed to conduct annual nursing aide performance reviews. This was evident for 5 out of 5 nursing aide performance appraisals, reviewed during the annual survey. The findings include: During an interview with the Assistant Director of Nursing (ADON) on 08/11/25 at 11:46 AM, the surveyor inquired about the process for conducting annual performance reviews. The ADON explained annual training was offered to nursing aides and stated the surveyor should speak with Human Resource (HR) #4 regarding annual performance reviews. The surveyor requested employee files including annual performance reviews, for geriatric nursing assistant (GNA) #45, GNA #46, GNA #22, GNA #47, and GNA #48. On 08/11/2025 at 12:30 PM, the ADON provided the surveyor with employee files for GNA #45, GNA #46, GNA #22, GNA #47, and GNA #48. A review of the files failed to show evidence that a performance review had been conducted within the past 12 months. The surveyor informed ADON the annual performance reviews were missing. The ADON stated she would search for the documentation. The ADON followed up the surveyor and explained, she was unable to locate the GNA's annual performance reviews. During an interview with Human Resource (HR) #4 on 08/11/25, at 3:44 PM, when asked about the process for GNA performance reviews, she stated that she informs supervisors of upcoming staff performance reviews and expects the supervisor to submit the completed forms once they were finished. When asked how she follows up if performance reviews were not received, the HR #4 stated that she would provide a verbal reminder to the supervisor that the performance review was due. The surveyor informed HR #4 of the missing annual performance reviews for GNA #45, GNA #46, GNA #22, GNA #47, and GNA #48. The HR #4 stated that she was unable to locate the annual performance reviews for those GNA's. At 4:17 PM, the surveyor informed both the Director of Nursing and ADON of the missing annual performance reviews for GNA #45, GNA #46, GNA #22, GNA #47, and GNA #48.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation and interviews, it was determined that facility staff failed to post the actual hours worked per shift for Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Medication Aide (CMA), Geriatric Nursing Assistant (GNA). This deficient practice was evident for 2 (Chesapeake and [NAME]) out of 2 units reviewed for posted nurse staffing information. The findings include: During the initial tour of Chesapeake Unit on 08/04/25 at 7:35AM, the surveyor observed a white board hanging on the wall dated 08/04/25. The whiteboard listed Nurse Unit Manager (UM) #7, six GNA's with their room assignments, LPN #35, LPN #9, and RN #11. However, the actual hours worked were not listed for any of the staff. A Resident Care Staffing Report sheet was taped to the white board, which included a sections for day, evening and night shifts, unit census, and nursing staff assignments. The area designated for actual hour worked was left blank. Multiple observations of nurse staffing information were made on Chesapeake and [NAME] units between 08/04/25 and 08/13/25. This observation showed that staff failed to document the hours worked for nursing staff. During an interview with UM #5, the surveyor asked what information should be listed on the nurse staffing whiteboard and form. The UM #5 stated that the current date, the unit census, and the number of RN's LPN's, CMA's, and GNA's working along with their assignments should be listed. The surveyor informed the UM #5 that the actual hours worked per shift must also be posted for each nursing staff. The Unit manager stated she was unaware of this requirement and would begin ensuring that the actual hours worked for each nursing staff are listed. On 08/13/25 the surveyor informed the Director of Nursing of the observations made between 08/04/25 and 08/13/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of narcotic record books and interviews with facility staff, it was determined that the facility failed to ensure narcotic record books were consistently signed by both incoming and outgoing nurses. This was evident for 5 out of 5 narcotic books reviewed during the facility's Medicare/Medicaid recertification survey. On 08/05/2025 at 7:40 AM, during a medication administration observation on the [NAME] Unit, the surveyor reviewed the narcotic record book and noted multiple missing signatures dating back to May 2025. More recent omissions included the weekend shifts from 08/01/2025 through 08/03/2025. At 7:44 AM on 08/05/2025, the unit manager Staff #5 was called for dual observation. She confirmed the missing signatures. When asked about facility protocol, she stated that narcotics were to be counted at the beginning and end of each shift by both the outgoing and incoming nurse, and that both nurses were required to sign the record. She acknowledged that the absence of signatures was inappropriate and not in compliance with protocol. On 08/05/2025 at 7:59 AM, during a separate medication administration observation on the Chesapeake Unit, the surveyor requested the narcotic record book from Licensed Practical Nurse (LPN) #35. Upon review, the surveyor identified additional missing signatures and also a missing signature from the incoming nurse during the morning shift on that day. When asked, LPN #35 confirmed that she had counted narcotics with the outgoing nurse but had not signed the book. When asked what the facility policy was regarding signing the narcotic book, she stated that both incoming nurses and outgoing nurses must sign the book. She subsequently signed the narcotic book. At 9:34 AM on 08/05/2025, the surveyor discussed these findings with the Director of Nursing (DON). The DON confirmed awareness of the issue through reports from unit managers after the medication observation with the surveyor. When asked about the facility's expectations regarding signing the narcotic record book, he stated that both the outgoing and incoming nurses were required to sign the narcotic record book to ensure accountability and prevent discrepancies. He further stated that licensed nurses would receive in-service education regarding appropriate narcotic record documentation. On 08/12/2025 at 10:06 AM, during a review of employee files related to staffing, the surveyor participated in a dual review of Registered Nurse (RN) #36's personnel record. Documentation revealed prior corrective action notices, including one dated 03/10/2025, citing failure to perform narcotic count sign-off with the off-going nurse. Additional corrective notices before and after that date were also noted.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Number of residents sampled: Number of residents cited: Based on record review and staff interviews, it was determined that the facility failed to ensure that resident Medication Regimen Review (MRR) recommendations were addressed by the provider. This was evident for 3 (Resident #5, #6, and #69) of 5 residents reviewed for unnecessary medications. The findings include: 1) Gradual Dosage Reduction (GDR) refers to the process of systematically reducing the dosage of medications, especially psychotropic drugs, over time, while carefully monitoring a patient's response to reduce reliance and dependence on certain medications, to find the lowest effective dose and to avoid unnecessary medication. On 08/06/2025 at 9:50 AM, review of the pharmacy medication regimen review (MRR) for Resident #69 showed that in June 2025 the pharmacy recommended a gradual dose reduction (GDR) of Alprazolam 0.25 mg one time a day, Alprazolam 0.25 mg every 12 hours, Gabapentin 600 mg two times a day and Quetiapine 50mg (Seroquel) two times a day. Further review revealed that Resident #69 was last seen for psychiatric evaluation on 05/16/2025. Notes indicated the psychiatrist determined benefits outweighed risks of GDR at that time. However, there was no evidence that the resident was re-evaluated by psychiatry after the pharmacy's June 2025 GDR recommendation. Further review of the resident's medical record on 08/06/2025 at 10:03 AM, revealed that the on 07/09/2025, the Medical Director (Staff #32) ordered an additional prescription of Seroquel (Quetiapine) 25 mg two times daily, in addition to the standing Quetiapine 50 mg two times daily, increasing the total daily dose to 75 mg at 0900 and 1700. However, there was no documentation that Resident #69 was re-evaluated by psychiatry after the pharmacy's June 2025 GDR recommendations. Additionally, there was no evidence that the attending provider responded to consultant pharmacist's recommendations or documented the rationale for the additional increase of Seroquel (Quetiapine) 25mg. During an interview on 08/06/2025 at 10:50 AM, the Director of Nursing (DON) was asked about the pharmacist's recommendation on 06/17/2025 for a gradual dose reduction (GDR) of Quetiapine 50 mg for Resident #69. The DON stated he had spoken with the Medical Director (Staff #32), who indicated that a GDR was not needed due to the resident's agitation. When asked for documentation supporting the decision not to reduce the medication and the rationale for continuation, the DON confirmed that no such documentation was available from either himself or the Medical Director(Staff #32). The DON further acknowledged that documentation should have been present to support the clinical decision regarding the resident's psychotropic medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/07/2025 at 10:57 AM, in a phone interview with the Medical Director, Staff #32, when he was asked if there was a gradual dosage reduction (GDR) in June and July 2025 according to the pharmacist recommendation, he stated that the IDT reviewed the psychotropics but determined to maintain medications and added that Resident #69 became agitated He also acknowledged that he ordered Quetiapine 25 mg on 07/09/2025 due to Resident #69's agitation but failed to document the rationale, the discussion regarding the pharmacy's GDR recommendation, or ordered non-pharmacological intervention. The Medical Director stated, It was an error from me; I should have documented the GDR discussion, the reason for the increase and ordered non-pharmacological interventions to resident #19's treatment order. 2a) A MRR is completed monthly by a pharmacist to ensure that each resident's medications that they take are safe. If recommendations are indicated, the physician addresses the recommendations by indicating they accept, decline, or can write an alternative response. On 08/05/2025 at 8:02 AM, an interview with the Director of Nursing revealed that the expectation was for the provider to address recommendations in MRR if there were irregularities found. Further interview revealed he keeps documentation of the MRRs in his office. The surveyor requested the last year of reviews for Resident #5. On 08/05/2025 at 10:20 AM, review of Resident #5's MRRs provided by the facility revealed an MRR dated 2/13/25 which indicated there were irregularities found by the pharmacist. Further review of the medical record failed to reveal that the irregularities were addressed. 2b) On 08/05/2025 at 10:24 AM, review of Resident #5's MRRs provided by the facility revealed an MRR dated 4/10/25 which indicated there were irregularities found by the pharmacist. Further review of the medical record failed to reveal that the irregularities were addressed. On 08/05/2025 at 11:26 AM, the surveyor reviewed the concern regarding the MRRs dated 2/13/25 and 4/10/25 with the Director of Nursing. He indicated he understood the concern. 3) On 08/05/25 at 12:37 PM, a review of Resident #6's medical record revealed that the monthly medication regimen reviews conducted between 08/12/24 and 07/16/25, and an irregularity was identified on 09/15/24. The surveyor requested to review the irregularity and the pharmacist's recommendation to the physician. Review of the pharmacist's recommendation dated 09/15/24 revealed that Resident #6 was prescribed Seroquel (Quetiapine) 50 milligram (mg), Lexapro (Escitalopram) 20 mg, and Haldol (Haloperidol) 2mg. The pharmacist recommendation note: please indicate if these medications are eligible for a gradual dose reduction (GDR) while concurrently monitoring for the emergence of depressive and/or withdrawal symptoms. Further review of the medical record showed that the Lexapro dosage was not addressed until 03/28/25. The Haldol dosage was not adjusted until 06/20/25, and Seroquel dosage was not adjusted until 06/06/25. There was no documentation from the physician indicating if they agreed or disagreed, nor any comments in response to the pharmacist's recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 08/05/25 at 1:06 PM, the DON acknowledged that monthly pharmacy reviews were completed for Resident #6 and that irregularities for Seroquel, Lexapro, and Haldol were identified on 09/15/24. The DON stated that the provider did not respond to the pharmacist's recommendations or make adjustments to the resident's medication until March and June 2025. When asked if the facility provided the resident with non-pharmacological interventions, the DON stated that he believed interventions were provided but was unable to provide documentation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews with facility staff, it was determined that the facility failed to ensure residents were free from unnecessary psychotropic medications. This was found to be evident for 1 (Resident #69) out of 2 residents reviewed for unnecessary medications during the facility's Medicare/Medicaid recertification survey. The findings include: Brief Interview for Mental Status (BIMS) 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. Gradual Dosage Reduction (GDR) refers to the process of systematically reducing the dosage of medications, especially psychotropic drugs, over time, while carefully monitoring a patient's response to reduce reliance and dependence on certain medications, to find the lowest effective dose and to avoid unnecessary medication. An Interdisciplinary Team (IDT) is a group of healthcare professionals from different disciplines who collaborate to provide comprehensive and coordinated care for a patient. They work together to assess the patient's needs, develop and implement a care plan, monitor the patient's progress, and communicate effectively with each other and the patient. On 08/06/2025 at 9:28 AM, the surveyor conducted a review of the medical record of Resident #69 and it revealed that he/she was admitted to the facility on [DATE] with diagnosis of Cerebral Aneurysm, Non-ruptured, Depression, Unspecified, Anxiety Disorder, Unspecified, Essential (Primary) Hypertension, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance, Shortness of Breath. His/her BIMS scores on 02/06/2025 and 5/14/2025 was 99 which indicated that the resident was unable to complete the interview. On 08/06/2025 at 9:50 AM, review of the pharmacy medication regimen review (MRR) showed that in June 2025 the pharmacy recommended a gradual dose reduction (GDR) of Alprazolam 0.25 mg one time a day, Alprazolam 0.25 mg every 12 hours, Gabapentin 600 mg two times a day and Quetiapine 50mg (Seroquel) two times a day. Further review revealed that Resident #69 was last seen for psychiatric evaluation on 03/14/2025, 04/11/2025, and 05/16/2025. Notes indicated the psychiatrist determined benefits outweighed risks of GDR at that time. However, there was no evidence that the resident was re-evaluated by psychiatry after the pharmacy's June 2025 GDR recommendation. On 08/06/2025 at 10:03 AM, the surveyor observed that on 07/09/2025, the Medical Director (Staff #32) ordered an additional prescription of Seroquel (Quetiapine) 25 mg BID, in addition to the standing Quetiapine 50 mg BID, increasing the total daily dose to 75 mg at 9:00 AM and 5:00 PM. On 08/06/2025 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. The note did not reflect whether non-pharmacological interventions were attempted prior to the medication increase. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/06/2025 at 10:50 AM, in an interview with the DON, when he was asked about the resident's psychotropic GDR on 06/17/2025. He stated that he spoke with the Medical Director (Staff #32) who stated that GDR was not needed due to agitation and when he was asked why Seroquel 25 mg was added to the resident's medication on 07/09/2025 alongside Quetiapine 50 mg. He stated that he spoke with the MD who placed the resident on the additional medication and when he was asked for the document regarding the need for the additional medication, he stated that there was no document to that effect either from him or from the medical director. When he was asked for the non-pharmacological intervention given to Resident #69 on 07/09/2025 when an agitation behavior was observed, he stated that there was none. On 08/07/2025 at 10:57 AM, in a phone interview with the Medical Director, Staff #32, When he was asked if there was a gradual dosage reduction (GDR) in June and July 2025 according to the pharmacist recommendation, he stated that the IDT reviewed the psychotropics but determined to maintain medications and added that Resident #69 became agitated and had verbal altercations with other residents on 07/03/2025 in which he/she was redirected and on 07/07/25 the Nurse Practitioner (Staff #40) had seen him/her and increased his/her Xanax to 5 mg. He also acknowledged that he ordered Seroquel (Quetiapine) 25 mg on 07/09/2025 due to Resident #69's agitation but failed to document the rationale, the discussion regarding the pharmacy's GDR recommendation, or ordered non-pharmacological intervention. The Medical Director stated, It was an error from me; I should have documented the GDR discussion, the reason for the increase and ordered non-pharmacological interventions to resident #69's treatment order.

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Chestertown Nursing and Rehab	415 Morgnec Road Chestertown, MD 21620

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility failed to ensure the 1) appropriate labeling and storage of medications and 2) appropriate temperature monitoring was maintained for the medication refrigerator. This was evident in 2 out of 5 medication carts observed and 1 out of 2 medication storage rooms observed during the facility's Medicare/Medicaid recertification survey.House Stock Medications are medications kept readily available on-site for general use by residents or patients, not specifically ordered for an individual. 1) On 08/05/2025 at 10:06 AM, during a medication administration observation on the [NAME] Unit, the surveyor observed one opened bottle each of Melatonin tablets, Vitamin B12 tablets, Magnesium Oxide tablets, and Guaifenesin extended-release expectorant that were not dated. At 10:10 AM on 08/05/2025, in an interview with Licensed Practical Nurse LPN #17, when she was asked for the expectation regarding dating house stock medications, she stated that whenever such bottles of medication were opened, the licensed nurse or Certified Medication Aide who opened the medications were expected to put an open date on it which should be visible enough for anyone to read. On 08/05/2025 at 10:16 AM, during a medication administration observation on the [NAME] Unit (200 hallway cart), 1 bottle of chewable Aspirin tablets, 1 Bottle of Bisacodyl tablets and 1 bottle of magnesium oxide was opened but without the open dates. On 08/05/2025 at 10:21 AM, in an interview with the unit manager, Staff #5, when she was asked for the facility's expectation regarding dating house stock medications, she stated that it was expected that all opened house stocks medications were dated accordingly. At 10:23 AM on 08/05/2025, when the concern was shared with the Assistant Director of Nursing (ADON) who walked into the unit while the surveyor was there, she stated that the medications would be removed from the carts 2) On 08/05/2025 at 10:35 AM, during a tour of the Chesapeake Unit medication room with Unit Manager Staff #7, the surveyor observed that the refrigerator temperature log was not signed from 08/01/2025 through 08/03/2025 and was also missing the morning shift entry on 08/05/2025. When the surveyor asked what the expectation was regarding checking the temperature logs, stated that temperatures were expected to be checked every morning by the night shift and every evening by the evening shift, with documentation required after each check. Copies of June and July medication room temperature logs were requested and provided. On 08/05/2025 at 10:43 AM, the surveyor reviewed temperature logs from June and July 2025 and it revealed the following: June 2025: temperature checks were not documented for five days, three evening shifts, and one morning shift. July 2025: the log was missing documentation for the evening shift on 07/31/2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/05/2025 at 10:48 AM, when the concern was discussed with the Director of Nursing (DON), he stated that staff education would be provided regarding completion of refrigerator temperature logs.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Number of residents sampled: Number of residents cited: Based on interviews and record reviews, it was determined that facility staff failed to refer a resident with worn down dentures for dental services in a timely manner. This deficient practice was evident for one resident (#10) reviewed for dental services during the annual survey. The findings include:During an interview with Resident #10 on 08/04/25 at 8:52 AM, the resident expressed concerns regarding their dentures. The resident stated that someone was supposed to schedule an appointment; however, the resident was unsure who was responsible for scheduling it or when the appointment would take place. On 08/04/25, a review of Resident #10's medical records revealed a progress note dated 04/6/24, by the Registered Dietitian (RD) #10. The RD documented that the resident reported missing teeth and stated that their dentures were causing difficulty with chewing and eating. During the visit, the resident also reported that their gums were sore and request soft textured food. The RD documented that she informed the kitchen, speech language pathologist (SLP), and activities personnel of the resident's dental concerns. A review of the medical records failed to show that the RD, SLP, kitchen staff, or activities personnel documented any dental follow up. A progress note written by the RD dated 10/02/24, documented that she visited the resident, who complained of difficulty chewing food due to worn dentures. The resident reported that their gums are sore and prefer soft foods. The RD again noted that the kitchen staff, SLP, and activities personnel were notified, and that the resident requested visits for menu choices. On 08/04/25 at 4:18 PM, during an interview with the Social Worker Assistant (SW) #8, the surveyor discussed Resident #10's dental and denture concerns that were documented by RD #10 on 04/06/25 and again on 10/02/24. The SW #8 explained that the resident expressed during a care plan meeting on 07/15/25, that they wanted dentures. She further explained that she was not aware of the resident's dental concerns until July 2025 and expressed that the RD had failed to inform her of the resident's ongoing dental problem. During an interview with the Director of Nursing (DON) on 08/04/25 at 4:51 PM, the surveyor informed him of the RD's progress notes and interview with the social worker. The surveyor discussed the lack of interventions to address the resident's dental concerns. The DON acknowledged that interventions had been delayed. The surveyor requested documentation indicating at the SLP, kitchen and activities personnel had assessed the resident.A review of SLP evaluation dated 10/02/24, showed an assessment note indicating that the resident reported difficulty chewing foods, that the resident's dentures were loose, and that their gums were sore. The SLP recommended changing the resident's diet to pureed textured. On 08/06/25 at 9:18 AM, during an interview with RD #10, she explained that risk management meetings are conducted weekly and that Resident #10's denture concerns were verbally discussed during the meetings. The RD #10 stated that she was concerned about the risk for aspiration and referred the resident to SLP, the kitchen and activities personnel. She further explained she expected the DON or other nursing staff to place a referral to address the resident's denture concerns.

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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 observation and interview with facility staff, it was determined that the facility 1) failed to maintain kitchen, kitchen equipment and surfaces in a sanitary condition to prevent the potential for food contamination 2) failed to ensure that food items were labeled and dated. This was found to be evident during the observations of the facility's kitchen food service operations during Medicare/Medicaid recertification survey. 1) On 08/04/2025 at 7:43 AM, during the initial facility tour with the Assistant Food Service Director (Staff #1), the surveyor observed five jars of different seasonings on the top shelf, all open, with visible seasoning particles scattered across the shelf. When the surveyor asked why the seasoning jars were not covered, she stated that she had just returned from vacation and that the night staff should have kept it covered. The food preparation sink had lots of white oily stains, when asked what was in the sink, she confirmed that the stains were from oily foods that were washed during the previous shift and proceeded to clean the sink.At 8:00 AM on 08/04/2025, the surveyor observed several dried and wet food stains on the kitchen walls and dried food stains on the counters and tables.At 8:11 AM on 08/04/2025, the three-compartment sink had white lime deposits on the faucets, and the three handwashing sinks in the kitchen were dirty with brown stains. Staff #2 was called for a dual observation and confirmed the sinks were dirty.2) On 08/04/2025 at 8:14 AM, during a continued tour of the kitchen with dietary aide Staff #2 accompanying the surveyor because the Assistant Food service Director, Staff # 1, was dishing out the meals. Inside the walk-in refrigerator, two bowls of lettuce, two bowls of cheese, about 6 pounds of raw ham, desserts (tomatoes, cucumbers and banana cream pies) and several bread rolls were seen with no dates or label.On 08/04/2025 at 8:20 AM, in an interview with the Staff #1, while staff #2 was present, when she asked when the unlabeled and undated food items were made, she stated that she just got back from vacation and did not know when they were made. When she was asked if the food items in the refrigerator should have been labelled and dated, she stated that the food items should have been dated and labelled and added that the right thing to do was to put dates and label on every food item. She went ahead to take the food items out of the refrigerator. Staff #2 also went ahead to date and label the food items, and he stated that the desserts were from lunch on 08/03/2025 and that the staff who placed it in the refrigerator should have put a date on it because nobody would have known when they were made or when the raw ham was taken out of the freezer to the refrigerator.At 10:40 AM on 08/04/2025, the surveyor discussed the kitchen concerns with the Nursing Home Administrator (NHA), the Director of Nursing (DON), and the [NAME] President of Clinical services. The NHA stated she would begin investigating immediately.At 10:55 AM on 08/04/2025, the NHA confirmed the surveyor's observations and stated that the dirty kitchen walls, sinks, and all other unclean surfaces would be deep cleaned in the early morning hours of 08/05/2025.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Number of residents sampled: Number of residents cited: Based on record reviews and interviews, it was determined that the facility staff failed to ensure 1) resident medical records were complete and accurate, and 2) resident medical records were maintained. This was evident for 3 (Resident #5, #6, and #80) of 4 residents reviewed for Preadmission Screening and Resident Review (PASARR), and 1 (Resident #97) of 42 residents reviewed during the annual survey. The findings include: 1a) Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings. On 08/05/2025 at 8:00 AM, a review of Resident #6's PASARR dated 09/16/21, revealed that in section A, one of three question was marked no. The instructions indicated that if any question in section A is answered no, the remainder of the form (section B, C, and D) must be completed. However, all 4 questions in section B were left blank resulting in a incomplete screening. On 08/05/25 the surveyor reviewed the PASARR with the Social Worker Assistant (SW) #8. During the review, the surveyor asked why section B of the form had been left blank. The SW #8 explained she was not working as a social worker at the time the form was completed and could not explain why the previous social worker failed to complete it. SW #8 further stated that PASARR forms should be fully completed. SW #8 stated that she would search facility files to determine if another PASARR form for Resident #6 existed and would follow up with the surveyor. Review of Resident #6's medical records on 08/05/25 at 11:51 AM, revealed the Regional Social Worker (SW) #9 completed a level 1 PASRR through the electronic platform named Telligen. On 08/06/25 at 8:44 AM, SW #8 provided the surveyor with a copy of the completed level 1 PASRR. 1b) On 08/04/2025 at 12:14 PM, review of Resident #5's medical record revealed a PASARR dated 2/27/2024, which failed to have section D.1 filled out. Section D.1 read, is the individual being admitted for convalescent care not to exceed 120 days due to an acute physical illness which required hospitalization and does not meet all criteria for an example hospital discharge?). On 08/04/2025 3:50 PM, an interview with Social Work Assistant (Staff #8) revealed that the expectation was for the PASSAR documents to be completed entirely based on the document instructions and accurately based on resident status. The surveyor requested she view the document on the computer which was present during the interview. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview, Staff #8 indicated that based on what was documented in section c, that section d should have not been filled out at all. She understood the concern. 1c) On 08/04/2025 at 12:19 PM, review of Resident #80's medical record revealed a PASARR dated 1/30/2019 which indicated a level II screening is required. Further review of the document revealed a section under section d which read, for positive ID screens, not covered under categorical determinations, check below. There was a check mark next to what read, this applicant has been cleared by the department for nursing facility admission. On 08/04/2025 3:55 PM, an interview with Social Work Assistant (Staff #8) revealed that the expectation was if a residents level I screening indicated a need for a level II there would be some documentation that the facility would keep of the result. At the same time, the surveyor requested she view the document on the computer which was present during the interview. She indicated that along with the check mark at the bottom, there would be an additional document, which she indicated the facility did not have for the PASARR dated 1/30/2019. 2) On 8/12/2025 at 6:34 AM, review of an anonymous complaint (incident #310742) revealed a concern regarding the resident's skin, and wounds that were identified when the resident was discharged to the hospital in 2022 that the complainant was unaware of (the last hospital discharge when the resident was not readmitted after). At the same time, further review of Resident #97's medical record failed to reveal skin and wound documentation after 5/5/2022. On 8/12/2025 at 12:35 PM, the surveyor requested the facility to provide the name of the facility which the resident was sent to. On 8/12/2025 at 3:22 PM, The Director of Nursing informed the surveyor that they had no further skin and wound documentation after 5/5/2022 leading up to the hospitalization, and that he was unable to identify what hospital the resident was sent to. The surveyor reviewed the concern.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Number of residents sampled: Number of residents cited: Based on observation and interview, it was determined that the facility failed to ensure linen was stored and processed to prevent the spread of infection. This was evident during 1 of 1 observation of the laundry room. The findings include:On 08/12/2025 at 10:31 AM, an initial observation of the laundry room revealed two separate rooms, one with exposed dirty linen in bins and one with clean linen that was folded on tables exposed without covering. The two rooms had a door in between which failed to be closed to prevent the spread of infection while linens were processed and stored. On 08/12/2025 at 10:35 AM, an interview with Director of Housekeeping (Staff #28) revealed that the door was kept open between the two rooms when he had started working at the facility, and it had been kept that way. He was unaware that it was an infection control concern. On 08/12/2025 at 11:21 AM, the surveyor reviewed the concern with the Director of Nursing, he understood the concern.

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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. Number of residents sampled: Number of residents cited: Based on record review and interview, it was determined that the facility failed to ensure residents had or were screened for the pneumococcal and influenza vaccinations as indicated. This was evident for 2 (Resident #43, #78) out of 5 residents screened for immunizations.The findings include:1) On 08/12/2025 at 7:53 AM, review Resident #43's immunization record failed to reveal any documentation of pneumococcal and influenza vaccinations.2) On 08/12/2025 at 7:55 AM, review of Resident #78's immunization record failed to reveal any documentation of the pneumococcal vaccination. On 08/12/2025 at 9:25 AM, the surveyor reviewed the concern with the Director of Nursing. He indicated he was aware the facility did not have a good process in place for resident immunization records and understood the concern.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Number of residents sampled: Number of residents cited: Based on record review and interview, it was determined that the facility failed to ensure that each resident was screened for and offered the COVID- 19 vaccination. This was evident for 2 (Resident #43, #78) out of 5 residents screened for immunizations.The findings include:1) On 08/12/2025 at 7:53 AM, review Resident #43's immunization record failed to reveal any documentation that indicated the resident was screened for and offered the COVID-19 vaccination.2) On 08/12/2025 at 7:55 AM, review of Resident #78's immunization record failed to reveal any documentation that indicated the resident was screened for and offered the COVID-19 vaccination.On 08/12/2025 at 9:25 AM, the surveyor reviewed the concern with the Director of Nursing. He indicated he was aware the facility did not have a good process in place for resident immunization screening and documentation, and understood the concern.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations and interviews, it was determined that the facility failed to ensure a safe and comfortable environment for residents and staff. This was evident during observations on the Chesapeake and [NAME] units during the annual survey. The findings include:1) On 8/4/25 at 11:31 AM, an observation of the Chesapeake unit revealed a locked closet with a 3-11 linen sign on the 300-teens hallway, which looked like a section of the door fell off next to the door code box/handle. This crack revealed the door latch exposed where staff and residents could see from the hallway.2) On 8/4/25 at 11:32 AM, further observation of the Chesapeake unit revealed a soiled utility room next to the 3-11 linen room on the 300-teens hallway. Inside the soiled utility room revealed cracked tiles on the floor in front of the square tub-looking drain.3) On 8/5/25 at 6:30 AM, an observation of the [NAME] unit shower room revealed the first shower stall in the shower room on the left. In the shower stall revealed a dark/black substance in between the tiles from the floor up until the steel grab bar (midway to the ceiling). The black substance was more distinct in the tiles within the corners of the shower stall.4) On 8/6/25 at 6:35 AM, an observation on the Chesapeake unit revealed room [ROOM NUMBER], 316, 318, and 328 which room entrance doors had cracked and were missing the coating of the door by the lower door hinge.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with the facility staff, it was determined that the facility failed to ensure effective pest control measures were implemented to prevent and control flies in food service and resident care areas. This was found to be evident during the observations of the facility's kitchen food service operations and in two residents (Resident #84 and #78) rooms during Medicare/Medicaid recertification survey.On 08/04/2025 at 7:44 AM, a surveyor observed multiple flies flying around Resident #84's room (room [ROOM NUMBER]) while the resident was resting in bed. When the surveyor asked if flies were often present, Resident #84 replied, Yes.On 08/04/2025 at 7:51 AM, during the continued initial tour of the kitchen, this surveyor observed multiple flies inside the kitchen. When asked why there were many flies, Staff #1 stated the back door was often left open, which allowed flies to enter, since the refuse area was located directly outside the door. At the time of the observation, the surveyor noted the kitchen exit door to the back of the building was open. Staff #1 stated that Staff #2 must have left the door open while taking out the trash.On 08/04/2025 at 8:12 AM, a surveyor observed flies flying around in the 300-teens hallway of the Chesapeake Unit.On 08/08/2025 at 9:19 AM, during an interview with Resident #78, a surveyor observed a fly flying in the resident's room. Resident #78 stated, I always see flies flying around.On 08/04/2025 at 9:35 AM, as food trays were being delivered in the 300-hallway of the Chesapeake Unit, a surveyor observed flies flying around the food cart and near residents who were eating their food.At 10:40 AM on 08/04/2025, this surveyor discussed the kitchen concerns with the Nursing Home Administrator (NHA), the Director of Nursing (DON), and the [NAME] President of Clinical services. The NHA stated she would begin investigating immediately.At 10:55 AM on 08/04/2025, the NHA confirmed this surveyor's observations and stated that the dirty kitchen walls, sinks, and all other unclean surfaces would be deep cleaned in the early morning hours of 08/05/2025. On 08/08/2025 at 9:49 AM, in an interview with the Maintenance Director (Staff #38), when he was when the facility last had a pest control visit, The surveyor interviewed the Maintenance Director and asked when the last pest control visit occurred. Staff #38 stated the pest control company had visited on 07/29/2025 and reported that the company came biweekly or as needed if concerns were identified. The surveyor requested the pest control log.At 9:53 AM on 08/08/2025, after the surveyor reviewed the pest control log, the surveyor asked what services the pest control company performs. The Maintenance Director (Staff #38) explained that the pest control company sprayed chemicals in the hallways, near doorways and treated the exterior, once in the spring and once in the fall. When asked about recent pest problems, he said none had been reported to him. He added that he depended on staff and residents to tell him if pests were seen, and that sticky traps were used in different parts of the building. When asked specifically about flies in the kitchen, he said they could be entering from the drains and that he had not been made aware of any concerns. He said he would inform pest control services immediately about the flies.During a walk-through with Staff #38 on 08/08/2025 at 10:05 AM, this surveyor observed four fly traps in the Chesapeake unit and two fly traps in the lobby area leading to the kitchen. When the surveyor and Staff #38 entered the kitchen, they both observed several flies in the food preparation area and Staff #38 informed the surveyor that the flies were probably entering from the kitchen drains and stated again that pest control would be contacted immediately.On 08/08/2025 at 10:14 AM, when the concern was discussed in the conference room with the Director of Nursing (DON) while Staff #38 was present, the DON stated that pest control visited the building every 2 weeks and as needed. The DON also added that pest control would be contacted immediately.

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	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

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Number of residents sampled: Number of residents cited: Based on interviews and administrative record reviews, it was determined that the facility failed to provide staff with the required Quality Assurance and Performance Improvement (QAPI) training. This deficient practice was evident for 7 out of 7 employee files reviewed during the annual survey. The findings include: During an interview with the Assistant Director of Nursing (ADON) on 08/11/25 at 11:46 AM, when asked about the process for training staff, she explained that she conducts ongoing training twice per month. She further explained that the facility held its annual competency skills fair in May 2025. The surveyor requested employee files to include education verifying that geriatric nursing assistant (GNA) #45, GNA #46, GNA #22, GNA #47, GNA #48, Licensed Practical Nurse (LPN) #35, and Registered Nurse (RN) #36 completed the required annual QAPI training for 2024.On 08/11/2025 at 12:30 PM, the ADON provided the surveyor with employee files for GNA #45, GNA #46, GNA #22, GNA #47, GNA #48, LPN #35, and RN #36. A review of the files failed to show evidence of required annual QAPI training. The surveyor informed the ADON that the education records were missing. The ADON stated she would search for the documentation. At 4:17 PM, the ADON provided the surveyor with a folder containing various employee education records. A review of the folder failed to show documentation of QAPI training for GNA #45, GNA #46, GNA #22, GNA #47, GNA #48, LPN #35, and RN #36. Both the Director of Nursing and ADON were informed of these findings.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Number of residents sampled: Number of residents cited: Based on interviews and administrative record reviews, it was determined that the facility failed to provide staff with mandatory infection prevention and control training. This deficient practice was evident for 7 out of 7 employee files reviewed during the annual survey. The findings include: During an interview with the Assistant Director of Nursing (ADON) on 08/11/25 at 11:46 AM, when asked about the process for training staff, she explained that she conducts ongoing training twice per month. She further explained that the facility held its annual competency skills fair in May 2025. The surveyor requested employee files to include education verifying that geriatric nursing assistant (GNA) #45, GNA #46, GNA #22, GNA #47, GNA #48, Licensed Practical Nurse (LPN) #35, and Registered Nurse (RN) #36 completed the required infection prevention and control training for 2024.On 08/11/2025 at 12:30 PM, the ADON provided the surveyor with employee files for GNA #45, GNA #46, GNA #22, GNA #47, GNA #48, LPN #35, and RN #36. A review of the files failed to show evidence of infection prevention and control training. The surveyor informed the ADON that the education records were missing. The ADON stated she would search for the documentation. At 4:17 PM, the ADON provided the surveyor with a folder containing various employee education records. A review of the folder failed to show documentation of infection prevention and control training for GNA #45, GNA #46, GNA #22, GNA #47, GNA #48, LPN #35, and RN #36. Both the Director of Nursing and ADON were informed of these findings.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Number of residents sampled: Number of residents cited: Based on interviews and administrative record reviews, it was determined that the facility failed to provide staff with compliance and ethics training. This deficient practice was evident for 7 out of 7 employee files reviewed during the annual survey. The findings include: During an interview with the Assistant Director of Nursing (ADON) on 08/11/25 at 11:46 AM, when asked about the process for training staff, she explained that she conducts ongoing training twice per month. She further explained that the facility held its annual competency skills fair in May 2025. The surveyor requested employee files to include education verifying that geriatric nursing assistant (GNA) #45, GNA #46, GNA #22, GNA #47, GNA #48, Licensed Practical Nurse (LPN) #35, and Registered Nurse (RN) #36 completed compliance and ethics training for 2024.On 08/11/2025 at 12:30 PM, the ADON provided the surveyor with employee files for GNA #45, GNA #46, GNA #22, GNA #47, GNA #48, LPN #35, and RN #36. A review of the files failed to show evidence of compliance and ethics training. The surveyor informed the ADON that the education records were missing. The ADON stated she would search for the documentation. At 4:17 PM, the ADON provided the surveyor with a folder containing various employee education records. A review of the folder failed to show documentation of compliance and ethics training for GNA #45, GNA #46, GNA #22, GNA #47, GNA #48, LPN #35, and RN #36. Both the Director of Nursing and ADON were informed of these findings.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Number of residents sampled: Number of residents cited: Based on interviews and administrative record reviews, it was determined that the facility failed to provide geriatric nursing assistants (GNA) with the required annual in-service training. This deficient practice was evident for 5 out of 5 GNA files reviewed during the annual survey. The findings include: During an interview with the Assistant Director of Nursing (ADON) on 08/11/25 at 11:46 AM, when asked about the process for annual training for GNA staff, she explained that she conducts ongoing training twice per month. She further explained that the facility held its annual competency skills fair in May 2025. The surveyor requested employee files to include education verifying that GNA #45, GNA #46, GNA #22, GNA #47, and GNA #48 completed the required annual in-service training for 2024.On 08/11/2025 at 12:30 PM, the ADON provided the surveyor with employee files for GNA #45, GNA #46, GNA #22, GNA #47, and GNA #48. A review of the files failed to show evidence of required annual in-service training. The surveyor informed the ADON that the education records were missing. The ADON stated she would search for the documentation. At 4:17 PM, the ADON provided the surveyor with a folder containing various employee education records. A review of the folder failed to show documentation of annual in-service training for GNA #45, GNA #46, GNA #22, GNA #47, and GNA #48. Both the Director of Nursing and ADON were informed of these findings.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Number of residents sampled: Number of residents cited: Based on interviews and administrative record reviews, it was determined that the facility failed to provide staff with dementia training. This deficient practice was evident for 7 out of 7 employee files reviewed during the annual survey. The findings include: During an interview with the Assistant Director of Nursing (ADON) on 08/11/25 at 11:46 AM, when asked about the process for training staff, she explained that she conducts ongoing training twice per month. She further explained that the facility held its annual competency skills fair in May 2025. The surveyor requested employee files to include education verifying that geriatric nursing assistant (GNA) #45, GNA #46, GNA #22, GNA #47, GNA #48, Licensed Practical Nurse (LPN) #35, and Registered Nurse (RN) #36 completed dementia training for 2024.On 08/11/2025 at 12:30 PM, the ADON provided the surveyor with employee files for GNA #45, GNA #46, GNA #22, GNA #47, GNA #48, LPN #35, and RN #36. A review of the files failed to show evidence of dementia training. The surveyor informed the ADON that the education records were missing. The ADON stated she would search for the documentation. At 4:17 PM, the ADON provided the surveyor with a folder containing various employee education records. A review of the folder failed to show documentation of dementia training for GNA #45, GNA #46, GNA #22, GNA #47, GNA #48, LPN #35, and RN #36. Both the Director of Nursing and ADON were informed of these findings.