STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215262	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Chester River Manor Corp	200 Morgnec Road Chestertown, MD 21620

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews, the facility staff failed to 1) ensure a resident was seen timely by the Urologist as ordered and 2) reassess and intervene for a resident with urinary catheter problems. This was evident for 1 (Resident #3) of 4 residents reviewed for urinary catheters during a complaint survey. This failure led to the hospitalization of Resident #3 with diagnosis to include urinary tract infection and acute kidney injury. The findings include:Review of Resident #3's medical record on 4/20/26 revealed the Resident was admitted to the facility on [DATE] from the hospital with a urinary catheter (Foley) and a diagnosis of retention of urine. 1) The facility staff failed to ensure the Resident was seen by the Urologist as ordered.Review of the hospital discharge instructions on 4/21/26 at 11:40 AM dated 3/25/26 revealed the Resident was to follow up with urology within 2 weeks.Further review of Resident #3's medical record revealed no evidence that the Resident went to a urology follow up appointment. Review of a nurse's note written on 4/3/26 at 12:22 PM stated: Resident returned from urologist appointment in Chestertown. Urology office made scheduling error and booked Resident appointment in [NAME]. Appointment will be rescheduled. MD (doctor)/ RP (resident representative) made aware.During an interview with LPN #3 on 4/20/26 at 12:22 PM, LPN #3 was asked about the Resident's urology follow up appointment. LPN #3 stated, I know it got messed up but the Resident told me it had been rescheduled. During an interview with UM #6 on 4/21/26 at 9:33 AM, UM #6 stated she was the one that called the Urology office and no one told her it was for [NAME], it was a Chestertown number. UM #6 stated the facility's transporter took the Resident to the appointment thinking it was in Chestertown, but when we found out it was scheduled in [NAME], the transporter returned with the Resident. UM #6 was asked when the Urology appointment was rescheduled for. UM #6 stated she would let me know.UM #6 followed up with the Surveyor on 4/21/26 at 10:59 AM and stated Resident #3's Urology appointment was rescheduled for 5/6/26. The Surveyor asked UM #6 if they could get an earlier appointment and UM #6 stated, No, that was the earliest appointment they had. During an interview with the Medical Director on 4/22/26 at 10:49 AM, the Surveyor asked the Medical Director if she was aware the Resident did not go to his/her Urology follow up appointment on 4/3/26 and it was rescheduled for 5/6/26. The Medical Director stated she was aware and believed the facility had the Resident on a wait list to get an earlier appointment.During interview with the Urology office scheduler on 4/22/26 at 12:45 PM, the Scheduler stated UM #3 called their office on 3/27/26 at 12:08 PM and cancelled the Resident's appointment on 4/1/26. The Scheduler stated the 4/1/26 appointment had been previously made on 3/23/26 (when the Resident was in the hospital). The Scheduler stated at that time, Our system notes says the 4/1/26 appointment was cancelled due to facility staff transportation. The Scheduler stated the Resident's appointment was rescheduled during that call on 3/27/26 for Friday 4/3/26. The Scheduler stated at that time the 4/3/26 appointment was confirmed with the [NAME] location, appointment time of 1 PM, and the Resident was seeing provider NP #35. The Scheduler stated she received a phone call from the facility on 4/3/26 at 2:09 PM to reschedule the 4/3/26 because the facility staff went to the wrong location. The Scheduler added that the Chestertown location is closed (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215262	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Chester River Manor Corp	200 Morgnec Road Chestertown, MD 21620

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	on Fridays, and they only see patients at the [NAME] office on Fridays. The Scheduler stated she offered the facility dates and they chose 5/6/26 for the next appointment. The Scheduler stated she documented in her notes they were offered earlier appointments but declined those dates. 2) The facility staff failed to reassess and intervene for Resident #3's urinary catheter problems.During an interview with GNA (geriatric nursing assistant) #4 on 4/20/26 at 12:16 PM, the Surveyor asked the GNA if she remembered Resident #3 and any issues with his/her urinary catheter. GNA #4 stated he/she only took care of the Resident one time but remembered his/her catheter was leaking.During an interview with LPN (Licensed Practical Nurse) #3 on 4/20/26 at 12:22 PM, the Surveyor asked if LPN #3 remembered Resident #3 and if there were any issues with his/her urinary catheter. LPN #3 stated: We were not to touch the catheter since it had to be changed by a Urologist. LPN #3 stated: He/she was always playing with the catheter, he/she would push it into him/her up to the Y. LPN #3 demonstrated with an unused catheter where the Resident would push on the catheter up to. LPN #3 stated she would educate the Resident that he/she couldn't do that and would adjust the catheter back to where it was supposed to be. LPN #3 was asked if the urinary catheter was leaking, she stated not when he/she first came in but then it started leaking. LPN #3 added sometimes it was and sometimes it wasn't. During an interview with Unit Manager (UM) #6 on 4/21/26 at 9:33 AM, UM #6 stated she remembered it was leaking and he/she would play with it a lot. We were instructed we could not take it out because it had to be replaced by Urology. The UM stated the catheter was draining. The UM was asked if the urinary output was recorded and she replied, yes on the MAR (Medication Administration Record).Review of Resident #3's April 2026 Mediation and Treatment Administration Records on 4/21/26 revealed no documentation of urinary output. On 4/21/26 at 11:00 AM, UM #6 confirmed the urinary outputs were not recorded on the MARs (Medication Administration Record) and provided the Surveyor with 2 nurses notes from LPN #22 on 3/28/26 at 11:28 PM and 3/29/26 at 7:30 AM that documented an amount of urinary output, no further documentation was provided to Surveyor.During an interview with RN #5 on 4/21/26 at 12:35 PM, RN #5 was asked about what she remembers about the Resident's urinary catheter. RN #5 stated that it was draining. RN#5 also stated she remembered one time a GNA told her that the Resident kept touching the catheter, she told the Resident not to touch it and as long as it's draining to keep it like that.During an interview with LPN #17 on 4/21/26 at 2:48 PM, LPN #17 stated the Resident's catheter was supposed to be changed by Urology and it was leaking. LPN #17 was asked what the staff used for the leaking, LPN #17 stated he/she wore a diaper.During an interview with GNA #21 on 4/22/26 at 7:48 AM, GNA #21 confirmed the Resident's catheter was leaking and when he would come in 3-11 shift the Resident would be wet and he would change him/her.During an interview with LPN #3 on 4/22/26 at 8:05 AM, the Surveyor asked if she ever notified a provider that the Resident's catheter was leaking, his/her discomfort with the catheter and the Resident pushing on the catheter. LPN #3 stated no, she told UM #6.During an interview with GNA #30 on 4/22/26 at 11:30 AM, GNA #30 stated she doesn't remember the day but she got report that the Resident's catheter was leaking. GNA #30 stated the catheter drained well for me. GNA #30 was asked if she had any concerns with the catheter. GNA #30 stated the Resident complained it was burning and she notified the nurse and they looked at it and said it was fine.Review of a nursing note on 3/29/26 at 7:30 AM, LPN #22 documented: Resident observed during rounds with wet incontinent pad. Adjusted catheter and emptied foley bag with 300 cc of clear yellow urine. Made Nurse Practitioner (NP) #28 aware, waiting for response.During an interview with LPN #22 on 4/22/26 at 8:20 AM, LPN #22 stated it was her first time taking care of the Resident on 3/29/26 and she noticed the catheter was leaking. She stated she notified NP #28 that morning and also reported to day shift nurse RN (Registered Nurse) #5. The Surveyor asked LPN #22 what else she remembered, LPN #22 stated she knew the Resident had a urologist appointment scheduled, the Resident's scrotum was red, and the Resident was annoyed he/she was wet. LPN #22 did state she believes she only took care of the Resident one more time the following night and doesn't remember the catheter leaking that night.Review on 4/21/26 of a nursing note written on 3/29/26 at 7:46 AM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215262	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Chester River Manor Corp	200 Morgnec Road Chestertown, MD 21620

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	revealed RN #5 documented: NP consulted with the Resident. According to the Resident his/her last visit to the ER (Emergency Room) after multiple attempts to insert a Foley by the ER nurses and the ER doctor, Urologist had to insert it. Order not to touch the Foley (leaking but draining yellow urine in the bag) Schedule follow up with Urologist. Review of NP #28's note dated 3/29/26 revealed no assessment or plan related to the Resident's urinary catheter.During an interview with NP #28 on 4/22/26 at 10:20 AM, NP #28 was asked why there is no documentation that Resident #3 had a urinary catheter, assessment of the catheter or plan related to the catheter. NP #28 stated he was in the facility early and had seen the Resident prior to staff telling him about the leakage from the urinary catheter. NP #28 stated: I knew the Urologist put in the urinary catheter, so I told the staff not to touch it. I told them to reinforce with gauze because I figured the leakage would be irritating to him/her. I knew he/she was supposed to be seen by the Urologist. The Surveyor told NP #28 the Resident did not see the Urologist on 4/3/26 as scheduled and asked if he knew that. NP #28 stated he was not aware of that. The Surveyor asked if he saw the Resident after that, NP #28 stated: I think I checked in on him/her, but I don't have any notes saying that. Review of the Medical Director's note dated 4/2/26 that was provided to the Surveyor on 4/22/26 revealed no assessment or plan related to Resident #3's urinary catheter.During an interview with the Medical Director on 4/22/26 at 10:49 AM, the Surveyor asked if she was aware of the Resident's urinary catheter. The Medical Director stated she was aware and knew it was inserted by the Urologist at the hospital and the Resident was to be seen by the Urologist. The Medical Director was asked if she was aware the Resident's catheter was leaking. She stated she believed the leakage to be mild and not a major thing and it was not a daily thing. The Medical Director was asked if she was aware the Resident had been pushing or manipulating his/her urinary catheter, she stated: No. The Medical Director was asked if she was aware the Resident had complaints of penile pain to the Pain Management physician on 4/7/26, she stated, No, that would be a concern. Review on 4/21/26 of a Pain Management physician note written on 4/7/26 revealed it stated: He is complaining of penile pain at the insertion site of his Foley catheter. Asking for consideration of removal of his catheter today. I referred him to the primary treatment team and his unit nurse for discussion.During an interview with the Pain Management physician on 4/22/26 at 9:14 AM, the Surveyor reviewed the note he wrote on 4/7/26 and asked if he advised the nursing staff of the Resident's complaint of penile pain and wanting his catheter out. The Pain Management physician stated, I do not recall if I told the nurse and would have to rely on my notes, but if a Resident is alert and oriented and discusses other concerns that I can't handle I will tell them to tell their nurse so it can be addressed.Review of NP #29's note dated 4/12/26 revealed no mention of the Resident's urinary catheter. The NP does document the Resident's genitourinary symptoms: no hematuria. Hematuria is blood in the urine.During an interview with NP #29 on 4/22/26 at 9:53 AM, NP #29 stated she saw the Resident on 4/12/26 for a requested visit regarding his/her blood sugars. NP #29 stated she had reviewed the medical record and knew his/her Foley shouldn't be touched. NP #29 stated he/she should have gone to his/her Urology follow up appointment but was not aware if he/she went or not. NP #29 stated she was unaware of any issues with the urinary catheter.Review of RN #5's nurse's note dated 4/12/26 at 11:44 PM (late entry for 4:00 PM), RN #5 documented: During the day the Resident is alert and oriented times 4. The resident had meds and meals. Therapy got him/her up in chair. While with the resident giving meds or during the rounds he/she did not verbalize any concerns. The Resident's family member was in to visit and stated the Resident was in a lot of pain and not feeling well and she is calling 911 to take him/her to the ER. Resident left the facility via stretcher.During an interview with RN #5 on 4/21/26 at 12:35 PM, RN #5 was asked what she remembered the day the Resident went to the hospital. RN #5 stated: that morning the Resident was sleeping during her first rounds, then got his/her blood sugar, then therapy got the Resident up in a chair for breakfast and then the Resident complained he/she was tired and wanted to go back to bed. RN #5 stated the family member approached her saying they need to send the Resident to ER, wasn't doing well, and in a lot of pain. RN #5 stated I told her I gave the Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215262	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Chester River Manor Corp	200 Morgnec Road Chestertown, MD 21620

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	pain medication already. I went to call the provider, but the family member already called 911.Review of Resident #3's hospital medical records on 4/21/26 for admission dated 4/12/26 revealed the Resident was admitted to the hospital with diagnosis to include urinary tract infection and acute kidney injury. The hospital ER nurse's note dated 4/12/26 at 4:32 PM states: Nurse called and spoke with facility staff (RN #36). She advised the Foley has been a problem since the first day of admission. The hospital ER nurse's note dated 4/12/26 at 4:38 PM states Foley upon arrival draining around catheter. No urine noted in Foley bag. 23 milliliters saline removed from balloon (is a 10-milliliter balloon). Patient immediately began to urinate. Was able to obtain 200 milliliters in urinal. New Foley catheter inserted. Patient immediately has 2000 milliliters output of milky yellow urine. Urine sample obtained and bag emptied. Patient now has approximately 400 milliliters red tinged urine in Foley bag.On 4/22/26 at 1:50 PM the Surveyor reviewed the concerns with the Director of Nursing, Administrator, Regional Nurse and Regional Director of Operations the facility staff failure to reassess and intervene for Resident #3's urinary catheter problems and ensure the Resident was followed with the Urologist within 2 weeks as ordered caused Resident #3 harm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215262	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Chester River Manor Corp	200 Morgnec Road Chestertown, MD 21620

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 2 (Residents #4, #3) of 9 residents reviewed during a complaint survey.The findings include: A medical record is the official documentation of a healthcare organization. As such, it must follow applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record must be legible and accurate. 1) On 4/20/26 at 10:10 AM a review of Resident #4's medical record revealed that Resident #4 was admitted to the facility on [DATE] with diagnoses including cutaneous abscess of the left lower limb, orthopedic aftercare, pathological fracture of the left femur, and disruption of external operation (surgical) wound. A review of Resident #4's March 2026 Treatment Administration Record (TAR) revealed a physician's order to cleanse the left knee area with a prescribed solution and cover the area with a dry dressing daily, beginning 3/14/26. The TAR had a blank space for 3/14/26. There were no nurse's initials indicating the treatment was completed, and there were no corresponding nursing notes. On 4/22/26 at 11:50 AM an interview was conducted with Registered Nurse (RN) #31. RN #31 was asked if she performed the dressing change on 3/14/26 as there was no documentation that the dressing was done. RN #31 stated that she remembered Resident #4 and knew she performed the resident's dressing on 3/14/26 because the resident was talking to her during the dressing change. RN #31 was able to describe the wound and the dressing. RN #31 stated she did not realize she failed to sign off that the treatment was completed. On 4/22/26 at 2:00 PM the Director of Nursing and the Nursing Home Administrator were informed of the concern. 2) The facility staff failed to ensure provider notes were included in Resident #3's medical record in a timely manner. Review of Resident #3's medical record on 4/20/26 revealed the Resident was admitted to the facility in March 2026 and discharged from the facility on 4/12/26. Review of Resident's paper medical record on 4/21/26 revealed no provider notes. Review of Resident's electronic medical record on 4/21/26 revealed the following provider notes: -History and Physical by the Medical Director dated 3/26/26 not uploaded in the Resident's medical record until 4/10/26.-Progress note from Nurse Practitioner #28 dated 3/29/26 not uploaded in the Resident's medical record until 4/20/26, after the Resident's discharge.-Progress note from Nurse Practitioner #29 dated 4/12/26 not uploaded in the Resident's medical record until 4/20/26, after the Resident's discharge. On 4/22/26 the Surveyor asked the Director of Nursing (DON) if there were any other provider notes (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215262	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Chester River Manor Corp	200 Morgnec Road Chestertown, MD 21620

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident #3 that were not in the medical record. The DON provided a paper progress note from the Medical Director dated 4/2/26 that the DON stated had not yet been included in the Resident's medical record. The Surveyor reviewed the facility's staff failure to include provider notes in Resident #3's medical record in a timely matter with the DON on 4/23/26 at 1:50 PM.