STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215269	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkton Nursing and Rehabilitation Center	1 Price Drive Elkton, MD 21921

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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. Based on observation and staff interview it was determined that facility staff failed to treat each resident in a dignified manner by 1) standing over a resident while feeding the resident, and 2) not placing a urinary catheter bag in a dignity bag. This was evident for 2 (#50, #45) of 57 residents reviewed during a complaint survey. The findings include: 1) On 6/25/25 at 12:25 PM observation was made of Resident #50 sitting in a wheelchair at the end of the hallway on the first-floor nursing unit. Geriatric Nursing Assistant (GNA) #20 was standing in front of Resident #50 feeding the resident his/her lunch. GNA #20 was not sitting next to the resident at eye level while feeding. On 7/2/25 at 1:29 PM the Director of Nursing (DON) was informed of the observation. The DON shook her head. 2) On 6/25/25 at 12:55 PM observation was made from the hallway of Resident #45 lying in bed eating lunch. Resident #45's Foley catheter bag was hanging off the bed frame on the right side of the bed, which was visible from the hallway, as the resident's bed was the closest bed to the door. A Foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. The resident's Foley catheter bag was not placed in a privacy/dignity bag to enhance privacy to the resident. Review of Resident #45's care plan, UTI (urinary tract infection) the resident admitted from the hospital with a diagnosis of UTI within the last 30 days that was created on 5/30/25, had the intervention, maintain catheter privacy bag. On 6/25/25 at 1:35 PM the DON took a tour with the surveyor and was shown the concern. The DON stated that when Resident #45 came back from the hospital the catheter bag should have been placed in a dignity bag.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review and interview, the facility staff failed to notify a resident's representative for a change in condition (Resident #28). This was evident for 1 of 57 residents reviewed during a complaint survey. The findings include: The facility staff failed to notify Resident #28's representative when a new medication was ordered. Review of Resident #28's medical record on 6/23/25 revealed the Resident was admitted to the facility in November 2024 with a diagnosis to include dementia. Dementia is a general term for a decline in mental ability severe enough to interfere with daily life. Further review of Resident's medical record revealed on 12/18/24 the physician ordered Seroquel 25 mg in the morning for depression and give 2 tablets by mouth at bedtime for depression. Seroquel is an antipsychotic medication used to treat mood conditions. Further review of Resident's medical record revealed no notification to the Resident's representative of the order for Seroquel. Review of Resident #28's December 2024 Medication Administration Record revealed the facility staff administered Seroquel on 12/18/24 and 12/19/24. The Resident was seen by the physician on 12/19/24 and the Seroquel was then discontinued. Interview with the Director of Nursing on 6/26/25 at 3:30 PM confirmed the facility staff failed to notify Resident #28's representative of the order for Seroquel on 12/18/24.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that facility staff failed to ensure that resident medical records remained private and confidential. This was evident for 1 of 3 nursing units observed during a complaint survey. The findings include: On 6/26/25 at 11:42 AM observation was made of Resident #12's electronic medical record displayed on an opened computer screen that was sitting on top of an unlocked and unattended medication cart on the first-floor nursing unit. The resident's medications were on display and the opportunity to look at additional information was available. The medication cart was sitting in the hallway outside of room [ROOM NUMBER]. On 6/26/25 at 11:44 AM Staff (LPN) #38 walked out of a resident's room and walked up to the medication cart where the surveyor was standing. The surveyor informed Staff #38 of the finding. Staff #38 stated, I made a mistake and left the computer screen open. On 7/2/25 at 1:29 PM the Director of Nursing was informed of the finding.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a complaint, observation of resident rooms, and interview, it was determined the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, comfortable interior. This was evident on 2 of 3 nursing units observed during a complaint survey. The findings include: On 6/23/25 at 9:51 AM a review of complaint MD00204546 was conducted. The complaint alleged that the wall behind a resident's bed was falling apart. On 6/23/25 at 7:45 AM a tour was conducted on the second-floor nursing unit. There were ceiling tiles that had brown round stains in the hallways. Outside of room [ROOM NUMBER] there were 5 ceiling tiles with brown stains. From room [ROOM NUMBER] to 260 there were 24 brown stained tiles. By the nurse's stations there were 7 stained tiles. From room [ROOM NUMBER] to the nurse's station there were 38 stained tiles. On 6/25/25 at 12:50 PM observation was made on the second-floor nursing units of the following environmental concerns: room [ROOM NUMBER]A: The molding was missing around the over-the-bed tray table. There were 2 ceiling tiles with large brown stains. room [ROOM NUMBER]A: The right wheelchair armrest for Resident #49 was missing 1 inch by 1 inch of vinyl in the front and along the side of the armrest. There was a ceiling tile missing in the bathroom. There were metal bars and wires exposed and there was a hole in the wall to the left of the toilet. There was spackle also on the wall that was not covered with paint. room [ROOM NUMBER]: The left wheelchair armrest was missing on Resident #48's wheelchair. Resident #48 was asked about the armrest and stated, it would be nice to have an armrest. The molding was missing from around the right edge and side of the footboard of the bed. room [ROOM NUMBER]: There were 4 ceiling tiles that had large brown stains on the side of the room by the door. The molding around the perimeter of the over-the-bed tray table was missing and the laminate was warped. room [ROOM NUMBER]: There were brown stained ceiling tiles above the bathroom door. room [ROOM NUMBER]: Resident #47's left wheelchair armrest was missing vinyl and there was approximately 2 inches of foam exposed. room [ROOM NUMBER]: The molding was missing around the perimeter of both over-the-bed tray tables in the room. room [ROOM NUMBER]: The molding was missing around the over-the-bed tray table. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]: The vinyl was cracked and missing on Resident #46's right wheelchair armrest. The left wall between the 2 beds in the room had an area with a hole that was depressed into the studs of the room. room [ROOM NUMBER]: The wallpaper border at the ceiling was torn and ripped away from the wall in multiple locations, especially above the window. room [ROOM NUMBER]: There was no base molding on the wall under the television and there was a gapping space between the wall and the base molding under the second television closest to the window. There was no molding on the perimeter of the over-the-bed tray table. There were 3 ceiling tiles with brown stains. Rooms 212, 219, 234, 235, and 236: There were ceiling tiles that had large brown stains. In the second-floor dining room Resident #8 was sitting in a Geri-chair. The vinyl on the left armrest was torn the entire length of the armrest with the underneath padding exposed. Observation was made in the first-floor administrative offices. There were brown stained ceiling tiles in the Admissions office and the Administrator's office. On 6/30/25 at 8:22 AM an interview of the Maintenance Director, Staff #5 was conducted. Staff #5 was informed of the concern with the amount of ceiling tiles with large brown stains. Staff #5 stated, we are getting the roof top unit repaired. It was replaced last year and because it doesn't have enough air return and it was freezing the duct work, it was making it sweat, and that is what the drip marks are on the ceiling tiles. We didn't know it until the summertime came this year. It was done in the winter. The first hot day it started dripping all over. It was leaking all over the ceiling tiles. I quit changing them because we were getting it fixed. They are supposed to be here today to put that economizer on and it has been so hot we have had to run the air conditioner. Staff #5 produced a service repair proposal dated 4/29/25. The proposal documented, the mechanic found unit capacity and airflow greater than required for space. Recommend installation of economizer hood/controls, evaporator freeze stats, and low ambient control module. The contract was signed on 5/7/25. As of 7/2/25 the work had not begun. Staff #5 was then informed of the other environmental concerns related to the over-the-bed tray tables. Staff #5 stated the tray tables were being replaced constantly. Whenever the admissions person does a daily room check and she writes down which ones need to be replaced, they get replaced. Staff #5 was asked if he did wheelchair audits. Staff #5 stated, we have the [NAME] program and the GNAs (geriatric nursing assistants) put in there anytime there is a problem that needs to be repaired. The housekeepers wash the wheelchairs, and the floor techs put them in when there is a problem, and they give me a list. Most comes through [NAME] which is our maintenance program. Staff #5 stated he would get right on the repairs. Observation of Resident #38's room on 6/25/25 at 11:32 AM revealed the tube feeding stains on the floor next to the Resident's bed. Further observation revealed 2 fall mats covered in debris and the fall mat on the left side of the Resident's bed was ripped exposing the fall mat padding. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/25 at 1:23 PM the Surveyor brought the 2nd floor Unit Manager (Staff #34) to Resident #38's room and Staff #34 confirmed the tube feeding stains on the floor and the Resident's fall mats were dirty and ripped.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on review of a complaint and interview, it was determined the facility failed to provide the residents with an environment that was free of misappropriation of property. This was evident for 1 (Resident #10) of 57 residents reviewed during a complaint survey. The findings include: On 6/26/25 at 8:00 AM a review of complaint MD00203621 was conducted. The complaint alleged that the facility had either lost or allowed Resident #10's PlayStation 5 to be stolen. The complaint alleged when Resident #10 was transferred to the hospital in December 2023, the facility had packed up the items in his/her room and put the items in storage. Resident #10 alleged that he/she was told everything was locked up in a safe place and now no one knows where the PlayStation was located. On 6/26/25 at 8:17 AM an interview was conducted with Staff #7, the social work director who stated, I heard about it but I'm not sure if a grievance was put in about it. I heard that it was missing, and it was going to be replaced. At that time the surveyor requested a copy of the invoice of when the PlayStation 5 was replaced. At 8:36 AM Staff #7 returned and stated she walked up to the resident's room and stated she saw the PlayStation 5 and it had been replaced. On 7/1/25 at 1:00 PM an interview of Resident #55, Resident #10's roommate, was conducted. Resident #55 stated, the PlayStation was stolen, and [he/she] had to pay for it. [He/she] went through all the channels and the Ombudsman. It has been gone since November 2023. On 7/1/25 at 1:09 AM an interview was conducted with the Assistant Director of Nursing (ADON) who stated that it was packed up when the resident went to the hospital. The Nursing Home Administrator (NHA) at the time received the grievance about it missing and he tagged a few people, and they did an entire building search. It was not found, and he was advised that it needed to be replaced. He didn't know who replaced it. On 7/2/25 at 10:47 AM an interview was conducted with Resident #10 who stated that the PlayStation went missing a year ago and he/she got tired of waiting for the facility to respond to the issue after having gone through the administrator, so he/she replaced it him/herself. Resident #10 stated, I had been sent out to the hospital, and it was in the facility's custody while I was gone. When I got back it was missing. I bought another one off Amazon. On 7/2/25 at 11:20 AM Resident #10 emailed a copy of the invoice for the PlayStation 5 from 5/1/24 for $499. 99. On 7/2/25 at 11:45 AM the current NHA stated he did not have a self-report for the incident, and no one knows when this happened, so he doesn't have a date to go off of. The NHA stated, I do not have a self-report or grievance. I spoke to the previous NHA he said he was not able to determine a timeline or whether there was a device. The current NHA was informed that the rest of the staff knew that the PlayStation was missing and that the ADON was at the facility during the time period and confirmed the PlayStation 5 was locked up.

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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. Based on review of a complaint and interview, it was determined the facility failed to report allegations of misappropriation of property to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (Resident #10) of 57 residents reviewed during the complaint survey. The findings include: On 6/26/25 at 8:00 AM a review of complaint MD00203621 was conducted. The complaint alleged that the facility had either lost or allowed Resident #10's PlayStation 5 to be stolen. The complaint alleged when Resident #10 was transferred to the hospital in December 2023, the facility had packed up the items in his/her room and put the items in storage. Resident #10 alleged that he/she was told everything was locked up in a safe place and now no one knows where the PlayStation was located. On 7/1/25 at 1:00 PM an interview of Resident #55, Resident #10's roommate, was conducted. Resident #55 stated, the PlayStation was stolen, and [he/she] had to pay for it. [He/she] went through all the channels and the Ombudsman. It has been gone since November. On 7/1/25 at 1:09 AM an interview was conducted with the Assistant Director of Nursing (ADON) who stated that it was packed up when the resident went to the hospital in December 2023. The Nursing Home Administrator (NHA) at the time received the grievance about it missing and he tagged a few people, and they did an entire building search. It was not found and he was advised that it needed to be replaced. He didn't know who replaced it. On 7/2/25 at 10:47 AM an interview was conducted with Resident #10 who stated that the PlayStation went missing a year ago and he/she got tired of waiting for the facility to respond to the issue after having gone through the administrator, so he/she replaced it him/herself. Resident #10 stated, I had been sent out to the hospital, and it was in the facility's custody while I was gone. When I got back it was missing. I bought another one off Amazon. On 7/2/25 at 11:45 AM the current NHA stated he did not have a self-report for the incident and no one knows when this happened so he doesn't have a date to go off of.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of a complaint and interview, it was determined the facility failed to conduct a complete investigation for allegations of misappropriation of property and failed to provide an investigation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (Resident #10) of 57 residents reviewed during the complaint survey. The findings include: On 6/26/25 at 8:00 AM a review of complaint MD00203621 was conducted. The complaint alleged that the facility had either lost or allowed Resident #10's PlayStation 5 to be stolen. The complaint alleged when Resident #10 was transferred to the hospital in December 2023, the facility had packed up the items in his/her room and put the items in storage. Resident #10 alleged that he/she was told everything was locked up in a safe place and now no one knows where the PlayStation was located. On 7/1/25 at 1:00 PM an interview of Resident #55, Resident #10's roommate, was conducted. Resident #55 stated, the PlayStation was stolen, and [he/she] had to pay for it. [He/she] went through all the channels and the Ombudsman. It has been gone since November. On 7/1/25 at 1:09 AM an interview was conducted with the Assistant Director of Nursing (ADON) who stated that it was packed up when the resident went to the hospital in December 2023. The Nursing Home Administrator (NHA) at the time received the grievance about it missing and he tagged a few people, and they did an entire building search. It was not found and he was advised that it needed to be replaced. He didn't know who replaced it. On 7/2/25 at 10:47 AM an interview was conducted with Resident #10 who stated that the PlayStation went missing a year ago and he/she got tired of waiting for the facility to respond to the issue after having gone through the administrator, so he/she replaced it him/herself. Resident #10 stated, I had been sent out to the hospital, and it was in the facility's custody while I was gone. When I got back it was missing. I bought another one off Amazon. On 7/2/25 at 11:45 AM the current NHA stated he did not have a self-report for the incident and did not have an investigation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 8 (#11, #41, #19, #34, #17, #4, #9, #26) of 57 residents reviewed for complaints during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 6/23/25 at 9:55 AM a review of Resident #11's medical record was conducted. Review of the MDS with an assessment reference date (ARD) of 6/11/24, Section K0200 B documented a weight of 70 lbs. Section K0300 Weight Loss 10% or more in last 6 months was documented, no. Review of the vital sign section of the medical record documented a weight of 90.4 lbs. on 1/1/24 which was a 20 lb. weight loss, which was greater than 20 percent. On 7/2/25 at 1:27 PM the MDS coordinators were interviewed and confirmed the findings. 2) On 6/24/25 at 1:06 PM a review of Resident #41's medical record was conducted. Review of the MDS with an ARD of 10/27/24, Section J, Falls, coded that no falls had occurred since the last MDS assessment. Review of a 10/2/24 SBAR (change in condition) note documented the resident had a fall on 10/2/24 at 16:00 (4 PM). The resident did not have any injuries. Review of a 10/4/24 SBAR note documented the resident had a fall on 10/4/24 at 16:15 (4:15 PM). The resident was found on the floor between the 2 beds in the bedroom. The resident did not have any injuries. On 7/1/25 at 7:55 AM an interview was conducted with the MDS coordinators. Both MDS assessments were reviewed and they confirmed the findings. 3) On 6/25/25 at 10:15 AM a review of Resident #19's medical record was conducted. Review of the admission MDS with an ARD of 7/1/24, medications, coded that Resident #19 had not received antibiotics, opioids, and hypoglycemics during the 7-day lookback period. Review of the June and July 2024 MAR documented that the antibiotic Cephalexin 500 mg. (2) was given every 6 hours beginning on 6/28/24 until 7/4/24 for a urinary tract infection. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medication Insulin Glargine 36 units was administered at bedtime every evening beginning on 6/27/24 for diabetes mellitus and insulin Lispro 4 units at bedtime for diabetes mellitus. The medication Buprenorphine HCl-Naloxone HCl Sublingual Film 8-2 MG (Buprenorphine HCl-Naloxone HCl Dihydrate), 1 film sublingually in the morning for Pain beginning on 6/27/24 to 7/5/24. This medication is considered an opioid. The facility failed to capture those medications. Review of the discharge MDS with an ARD of 8/5/24, Section N, coded that the resident had not received hypoglycemics. Review of Resident #19's August 2024 MAR documented that the resident received insulin. On 7/1/25 at 7:55 AM an interview was conducted with LPN #31 and LPN #32, MDS coordinators, who confirmed the findings. 4) On 6/25/25 at 11:45 AM a review of Resident #34's medical was conducted. Review of Resident #34's April 2025 and May 2025 MAR documented the resident received Novolin FlexPen 10 units 2 times per day and Humalog KwikPen 5 units before meals for diabetes mellitus. Review of the admission MDS with an ARD of 4/25/25, the DCRA assessment with an ARD of 4/26/25, the 5-day Medicare MDS assessment with an ARD of 5/9/25 and the discharge assessment with an ARD of 5/13/25, Section N, medications, failed to capture the use of hypoglycemics. Review of the May 2025 MAR documented on 5/4/25 at 16:28 PM that Resident #34 received Acetaminophen 325 mg. (2) for pain at a level of 3. Review of the 5-day Medicare MDS assessment with an ARD of 5/9/25, section J0100 B, received prn (when necessary) pain medications was coded, no. The facility failed to capture the pain medication. On 7/2/25 at 1:27 PM the MDS coordinators were interviewed and confirmed the findings. 5) On 6/26/25 at 7:51 AM a review of Resident #17's medical record was conducted. Review of the admission MDS with an ARD of 6/6/24, Section N, Medications, failed to capture the PPD injection. Review of Resident #17's June 2024 MAR documented, Tuberculin PPD Solution 5 UNIT/0.1ML Inject 0.1 ml intradermally at bedtime for TB. The injection was documented as administered on 6/2/24 at 2000 (8 PM). On 7/1/25 at 7:59 AM an interview was conducted with the MDS coordinators who confirmed the findings. 6) On 6/26/25 at 12:20 PM a review of Resident #4's medical record was conducted. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 1/21/24 MDS, Section J, pain medication, was coded, no which indicated Resident #4 did not receive pain medication in the 7 day lookback period. Review of Resident #4's January 2024 MAR documented the pain reliever Ibuprofen 400 MG, give 1 tablet by mouth every 6 hours as needed for pain. The order was written on 1/8/24. It was documented that Resident #4 received Ibuprofen on 1/21/24 at 00:33 for a pain level of 4. The facility failed to capture the use of ibuprofen. On 7/2/25 at 1:30 PM an interview was conducted with LPN #31 and LPN #32, MDS coordinators, who confirmed the findings. 7) On 6/27/25 at 11:31 AM a review of Resident #9's medical record was conducted. Review of Resident #9's February and April 2024 MARs documented the resident received Aspirin 81 Oral Tablet Chewable (Aspirin),1 tablet by mouth in the morning for coronary artery disease (CAD). The medication was started on 2/21/24 and discontinued on 4/17/24. Aspirin is considered an antiplatelet medication. Review of the 2/26/24 and 4/16/24 MDS assessments, Section N, medications, failed to capture the use of Aspirin as antiplatelet was coded, no. On 7/1/25 at 7:55 AM an interview was conducted with LPN #31 and LPN #32, MDS coordinators, who confirmed the findings. 8) On 6/30/25 at 11:00 AM a review of Resident #26's medical record was conducted. Review of the MDS assessments with an ARD of 11/12/24, 11/14/24 and 11/26/24, Section J, pain, J0100A received scheduled pain medication, was answered, no. Review of Resident #26's November 2024 MAR documented the resident received, Lidocaine External Patch 5 % (Lidocaine), Apply to skin topically in the morning for pain every day. The facility failed to capture the every day use of pain medication. Review of the MDS assessments with an ARD of 11/12/24 and 11/14/24, Section J0100B, received PRN (when needed) pain medications or was offered and declined, was answered, no. Review of the November 2024 MAR documented the medication Oxycodone 5 mg/5ml, give 2.5 ml via g-tube every 4 hours as needed for pain. The oxycodone was administered on 11/12/24. Review of section N, medications for the 11/12/24 and 11/14/24 MDS assessments documented Resident #26 did not receive any antibiotic medication. Review of the November 2024 MAR documented, Mupirocin External Ointment 2 % (Mupirocin) Apply to skin topically three times a day for bacterial infection. The ointment was applied to the skin from 11/7/24 to 11/13/24, therefore should have been captured in the assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 11/26/24 MDS assessment, Section N, documented Resident #26 received an opioid medication within the previous 7 days of the assessment. Review of the November 2024 documented that Resident #26 only received the oxycodone (opioid) on 11/12/24. The facility should have coded opioid as no. On 7/1/25 at 7:55 AM an interview was conducted with LPN #31 and LPN #32, MDS coordinators, who confirmed the findings.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on complaint review, record review, and interview it was determined that the facility failed to provide residents and or resident's responsible party (RP) a copy of their baseline care plan along with a copy of their admission medications. This was evident for 1 (Resident #6) of 57 residents reviewed during a complaint survey. The findings include: The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive. On 6/26/25 at 10:17 AM a review of complaint MD00202545 alleged that Resident #6 was admitted in December 2023 and the RP had requested communication several times and received no return calls. Resident #6's medical record was reviewed and revealed Resident #6 was admitted to the facility in December 2023 with diagnoses that included but were not limited to nondisplaced fracture of lateral condyle of the left humerus. The resident had a cast on the left arm. Resident #6 was his/her own responsible party. There was no baseline care plan found in Resident #6's medical record. There was no documentation that a complete baseline care plan was done and that a list of medications was given to the resident or responsible party. In the evaluation section of Resident #6's medical record was a Baseline Care Plan initiation dated 12/22/23. There were 3 boxes. The first box was checked off and stated the care plan had been initiated. The second box was checked off that a baseline care plan had been reviewed with the resident and/or responsible party. The third box was blank. The third box stated, copy of baseline care plan and copy of medications have been given to the resident and/or responsible party. The check marks were done by LPN #17/unit manager. On 7/2/25 at 11:30 AM an interview was conducted with LPN #17. LPN #17 stated that she normally will check off the box and review it with the resident or RP. LPN #17 stated she never gets a signature on the baseline care plan. LPN #17 stated the baseline care plan was normally uploaded in the system. LPN #17 concurred that there was no evidence that she gave the baseline care plan along with a list of medications to the resident and she stated she does not remember if she gave it or did not give it.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint review, medical record review and interview, it was determined the facility staff failed to provide needed activities of daily living (ADL) for a resident totally dependent on bathing assistance (Resident #30). This was evident for 1 of 57 residents reviewed during a complaint survey. The findings include: Review of complaint MD00214497 regarding Resident #30's had not received showers on Mondays and Thursdays as scheduled even though the Resident's representative asked the facility staff to give the Resident showers. Review of Resident #30's medical record on 6/26/25 revealed the Resident was admitted to the facility on [DATE] and discharged from the facility on 4/4/25. The Resident diagnosis included hemiplegia and hemiparesis following cerebral infarction. Hemiparesis is a condition characterized by weakness on one side of the body. Further review of Resident #30's medical record revealed the facility staff completed an admission MDS (Minimum Data Set) assessment on 1/28/25 and coded the Resident in Section GG as dependent for shower/bathe self. Review of Resident #30's care plans revealed the Resident had a care plan entitled, Resident requires assistance with their activities of daily living due to reduced physical mobility that was initiated on 1/24/25. Review of Resident #30's Task List revealed the Resident was scheduled for showers on Mondays and Thursdays. Review of the GNA (geriatric nursing assistant) documentation from 1/24/25 until discharge on [DATE], the Resident did not receive showers on the following days: 1/30, 2/3, 2/20, 3/6, 3/10, 3/20, and 3/24/25. During interview with the Director of Nursing (DON) on 6/30/25 at 2:10 PM, the DON confirmed the facility staff failed to administer showers as scheduled for Resident #30 on 1/30, 2/3, 2/20, 3/6, 3/10, 3/20 and 3/24/25.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaints, medical record review, and interviews, it was determined the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice. This was evident for 5 (#20, #17, #3, #13, #38) of 57 residents reviewed during a complaint survey. The findings include: 1) The facility failed to ensure the resident was transported to the hospital in a safe manner. On 6/26/25 at 2:05 PM a review of complaint MD00208984 alleged that Resident #20 had congestive heart failure and as a result the resident's hands, face, and legs were swollen and painful. It was alleged that the physician wanted the resident to be evaluated by an emergency doctor, however the resident was to go to the hospital as a non-emergency transport. The complaint alleged that the resident was sent to the emergency room in a taxicab and was let out at the front emergency room entrance and had to wait 20 minutes before a security guard assisted the resident into the emergency room. Review of Resident #20's medical record revealed Resident #20 had diagnoses that included but were not limited to chronic congestive heart failure, seizures, type 2 diabetes mellitus with hyperglycemia and neuropathy, and generalized anxiety disorder. Further review of the medical record revealed the resident was alert and oriented to person, place, and time, and that the resident was their own responsible party. Review of an 8/5/24 at 22:42 PM nursing note documented a SBAR (change in condition note) that documented Resident #20 had a seizure that lasted approximately 5 minutes. A telehealth visit was done on 8/5/24 at 23:17 PM and the resident was now alert and oriented and better now but reports being, tired. Review of an 8/7/24 at 00:14 AM telehealth evaluation documented that Resident #20's Keppra level (seizure medication) was elevated. It was documented that the telehealth physician stated, had seizure yesterday at current dose. Will defer titration to house provider who has established neurologic knowledge of patient. There was an order to flag results for house provider and to notify physician of any changes. An 8/7/24 at 10:00 AM health status note documented that the physician was aware of the Keppra level. MD with orders to send resident to ER for fluid overload, seizure activity. Resident aware and transportation initiated by unit clerk. An 8/724 at 13:19 PM SBAR (change in condition) note documented, MD in house and spoke with resident regarding abnormal labs, seizure activity, and edema. MD with orders to transfer resident to ER. It was then documented, transfer to ER via non-emergency transport. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/25 at 7:45 AM an interview was conducted with LPN #34, the unit manager for the second floor. She stated that for non-emergency the wheelchair people would go by taxi. LPN #34 stated Resident #20 was able to wheel him/herself in the wheelchair and that the resident did not have an escort when going non-emergent. LPN #34 stated, normally they would wheel him/her into the emergency room. If we were to call 911 and he/she wasn't showing any symptoms they would tell us it was non-emergency. If they are capable of wheeling themselves around they can go by themselves. The policy has since changed, and now [name] taxi requires someone to accompany the resident. On 6/27/25 at 8:01 AM an interview was conducted with Staff #26, the unit secretary, who stated that the resident normally had someone go with him/her. Staff #26 stated, we always send a GNA (geriatric nursing assistant). On 6/27/25 at 10:51 AM an interview was conducted with Physician #25 and the physician's assistant (PA) #28. Physician #25 stated, my understanding is that if someone is being transported, it is my expectation that they were being taken into the triage area. [He/she] is the typical patient that you send to cardiologist office that would get an IV push of Lasix (diuretic) and then we tweak it off. That is why I was ok with non-emergent. I was not aware of that (not being escorted into the hospital) and would have raised holy hell. We will have to change the way we order transfers out. 2) The facility failed to assess and do follow-up assessments after a resident had a fall, notify the physician, and document that the resident had a fall. On 6/26/25 at 7:51 AM a review of complaint MD00208191 and facility reported incident MD00208302 revealed Resident #17 fell off the bed on 7/28/24 around 9:00 PM. Review of a written statement from LPN #17, the first-floor unit manager, documented that she interviewed Resident #17 on 7/29/24 and the resident stated that while he/she was being changed around 9:00 PM the previous shift, he rolled out of bed while being changed. Review of a written statement from LPN #22 documented that the date of the incident was 7/28/24 between 9 pm and 10 pm. The written statement documented that the GNA (geriatric nursing assistant) told LPN #22 that the resident fell and can she help get the resident off the floor. LPN #22 documented that the resident was sitting on his/her buttocks on the floor with no sign of distress or pain. The resident was assessed for injuries at that time. Review of Resident #17's medical record failed to produce documentation on 7/28/24 that the resident fell. There were no follow-up assessments of the resident after the fall. There was no documentation in the medical record until a medical progress note was written on 7/29/24 at 10:31 AM, which was at least 12 hours after the incident. The note documented that the resident had sustained a fall earlier in the year that had resulted in surgery for a right hip repair. The physician documented, [he/she] does report a fall last night from the bed and is complaining of L hip pain as a result. The physician ordered an x-ray of the pelvis and left hip to evaluate for fracture. Review of a 7/29/24 at 11:40 AM SBAR (change in condition) note was entered into the electronic medical record and documented the situation as, Falls. This was 14 hours after the fall occurred. The vital signs that were documented did not correlate to the time of the fall. The blood pressure reading was done on 7/29/24 at 6:32 AM. The pulse, pulse oximetry, respiratory rate, and temperature was documented on 7/28/24 at 11:49 AM, not around 9 PM on 7/28/24 when the fall occurred. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Falls Management Program Policy that was given to the surveyor by the DON on 6/26/25 at 10:12 AM revealed the procedure, Fall Occurrence, 1. notify the provider, responsible party, and/or EMS if indicated, as well as the supervisor/administrative personnel as appropriate. Evaluate, monitor, and document patient response every shift for 72 hours post fall. On 6/27/25 at 6:53 AM an interview was conducted with LPN #22. LPN #22 confirmed that she forgot to document in the medical record after the fall. LPN #22 said she was busy that night and that the resident did not have any injuries. LPN #22 stated, It skipped my mind. I wasn't familiar with the process at that time. I am now. I was written up and retrained on documentation. On 6/30/25 at 12:08 PM an interview was conducted with the Director of Nursing (DON). Reviewed the findings with the DON and she confirmed there was no assessment, no timely change in condition, no physician notification, and no documentation until the next day. 3) The facility staff failed to conduct neurological (neuro) checks after the resident had an unwitnessed fall. A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. On 6/30/25 at 2:04 PM a review of complaint MD00201479 revealed Resident #3 had falls while at the facility. Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] from an acute care facility with diagnoses that included metabolic encephalopathy and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominate side. Review of a 1/5/24 at 4:03 AM fall note documented Resident #3 had an unwitnessed fall with no injury, found lying to the right side of the bed on the floor. The physician was notified and the primary care provider feedback recommended to, continue with neuro checks per facility protocol. Review of a 1/8/24 at 8:54 AM and 14:34 PM fall note documented, found resident next to bed on the floor. Neither fall was witnessed by staff. Review of a 1/9/24 at 3:10 AM SBAR (change in condition) note documented falls, A staff member called me to inform me that they found a resident sitting on the floor. The resident insisted that [he/she] wanted to walk and leave. The note continued, currently, neurological assessment is in progress. Review of the assessment/evaluation section of the electronic medical record and the miscellaneous section of the medical record failed to produce evidence of neuro checks. On 7/2/25 at 12:20 PM an interview was conducted with the Assistant Director of Nursing (ADON) who stated, I know we used to do neuro checks on paper and we switched over to PCC (electronic medical record system) but I don't know the date of that. The ADON confirmed the neuro checks were not in the computer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/25 at 1:28 PM the DON brought back the paper request from the surveyor that requested copies of the neuro checks. The DON stated there were no neuro checks done after 4 unwitnessed falls.4) The facility staff failed to properly perform neuro checks after an unwitnessed fall for Resident #13. Review of the facility's Neurological Assessment policy provided by the Director of Nursing (DON) revealed the facility staff are to complete assessment every 15 minutes for the first hour, every 30 minutes for the next 2 hours, and every hour for the next four hours. Review of Resident #13's medical record on 6/25/25 revealed a Fall Note on 6/5/24 at 11:15 PM that stated Resident was observed sitting on the floor with his/her back against the bed, at the foot of the bed. Resident stated he/she rolled out of the bed. Further review of Resident #13's medical record revealed a Fall Evaluation note on 6/6/25 at 3:05 AM that stated, Patient had an unwitnessed fall from bed, Neuro checks are being performed per protocol. Patient is on Eliquis everyday. Eliquis is a blood thinner medication. Review of the neuro checks for Resident #13 revealed: a) The neuro check on 6/5/24 at 11:30 PM included pulse and blood pressure that were from 6/5/24 at 11:30 PM, but temperature from 6/6/24 at 12:20 AM and respirations from 6/5/24 at 11:02 PM. b) There were no neuro checks documented for 6/6/24 at 12 AM, 12:30 AM, 3 AM and 4 AM. Interview with the DON on 6/27/25 at 2:10 PM confirmed the facility staff completed neuro checks for Resident #13 at incorrect time intervals per facility protocol and inaccurately on 6/5 and 6/6/24. 5) The facility staff failed to send Resident #38 out to the hospital timely after a fall on 4/19/25. Review of Resident #38's medical record on 6/25/25 revealed the Resident was admitted to the facility in March 2025 with a diagnosis to include seizures and intracerebral hemorrhage. Intracerebral hemorrhage (ICH), also known as hemorrhagic stroke, is a severe medical condition where bleeding occurs within the brain tissue itself. Further review of Resident #38's medical record revealed the Resident had a fall on 4/19/25. Review of the Advanced Nurse Practitioner's note on 4/19/25 with a Date of Service of 4/19/25 at 3:28 AM that stated Patient had a non-injury fall, no evidence of trauma observed/assessed. Neuros within normal limit, patient had recent skull surgery and history of intracerebral hemorrhage and hydrocephalus. Patient endorsed hitting back of his/her head. Will transfer for imaging. Order: Transfer to Emergency Department. Further review of Resident #38's medical record revealed the facility staff did not send the Resident out to the emergency room until after 6 AM on 4/19/25. Interview with the Director of Nursing on 7/1/25 at 7:40 AM the facility staff failed to send Resident #38 to the emergency room timely on 4/19/25.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview and medical record review, the facility staff failed to ensure a resident had glasses (Resident #12). This evident for 1 of 57 residents reviewed during a complaint survey. The findings include: During interview with Resident #12 on 6/25/25 at 10:10 AM, the Resident stated he has been asking staff to get him/her glasses. The Resident stated when he/she went out to the hospital last year and returned his/her glasses have been missing. Observation of the Resident on 6/25/25 at 10:10 AM and 6/30/25 at 8:50 AM the Resident did not have glasses. Review of Resident's medical record revealed the Resident was seen by the eye doctor on 8/16/2024 and the eye doctor documented the Resident had readers assigned. Interview with the Director of Nursing on 6/27/25 confirmed the Resident did not have glasses and the facility staff would assist in getting the Resident glasses.

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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. Based on medical record review and interview, the facility staff failed to provide treatment/services to prevent/heal pressures ulcers (Resident #32). This is evident for 1 of 3 residents reviewed for pressure ulcers during a complaint survey. The findings include: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). Review of Resident #32's medical record on 6/26/25 revealed the Resident was admitted to the facility in October 2022 and had diagnosis to include Stage III pressure ulcer to the right ankle. Further review of Resident's medical record revealed the Wound Nurse Practitioner assessed the Resident on 12/31/24 to have a Stage III pressure ulcer to the right ankle. Further review of the Resident's medical record revealed the facility staff failed to do weekly skin assessments on 2/11, 2/18, 3/20 and 3/27/25 to include measurements and treatment recommendations. Further review of Resident #32's medical record revealed the Resident returned from the hospital on 2/27/25 and the facility staff failed to provide any treatment for Resident's right ankle pressure ulcer until 3/4/25, 5 days later. Interview with the Director of Nursing on 6/27/25 at 1:04 PM confirmed the facility staff failed to do weekly skin assessments of Resident #32's right ankle wound on 2/11, 2/18, 3/20 and 3/27/25 and failed to provide wound treatment on 2/28, 3/1, 3/2 and 3/3/2025.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and medical record review, the facility staff failed to ensure fall mats were properly in place for a resident with a history of a fall (Resident #38). This was evident for 1 of 4 residents reviewed for falls during a complaint survey. The findings include: Review of Resident #38's medical record on 6/25/25 revealed the Resident was admitted to the facility in March 2025 with a diagnosis to include seizures. Further review of Resident #38's medical record revealed the Resident had a fall on 4/19/25. Review of Resident #38's care plans revealed the Resident had a care plan initiated on 4/20/25 entitled Resident had an actual fall and is at risk for falls with an intervention of fall mats on floor at bedside while in bed. Observation of Resident #38 on 6/25/25 at 11:32 AM revealed the Resident in bed with the fall mat on the Resident's left side of bed was turned and against the wall at the head of the bed and not next to the left side of the Resident's bed. Observation of Resident #38 on 6/25/25 at 1:23 PM with the Unit Manager (Staff #34) present revealed the Resident in bed with the fall mat on the Resident's left side of bed was turned and against the wall at the head of the bed and not next to the left side of the Resident's bed. Interview with Staff #34 at that time confirmed the Surveyor's observations and that the Resident is to have fall mats next to the Resident's bed at all times.

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F 0690 Level of Harm - Minimal harm or potential for 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. Based on observation, record review, and interview, it was determined the facility failed to provide the appropriate care and services to prevent urinary tract infections. This was evident for 1 (Resident #45) of 57 residents reviewed during a complaint survey. The findings include: A Foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. On 6/25/25 at 12:55 PM observation was made from the hallway of Resident #45 lying in bed eating lunch. Resident #45 had a Foley catheter that was draining yellow urine. The Foley catheter and the urine was visible from the hallway. Upon entering the room observation was made of the bottom of the catheter bag and the blue tubing touching the floor. On the door there was a sign that stated, enhanced barrier precautions. On 6/25/25 at 1:10 PM a review of Resident #45's medical record revealed a 5/12/25 progress note that documented the resident has had multiple admissions to the hospital and on 4/22/25 was presented to the hospital with fevers, chills and hypoxia. The resident was admitted for sepsis. A Foley catheter was placed, patient was seen by urology and completed a course of cefepime for pseudomonas UTI (urinary tract infection). A 5/15/25 change in condition note documented Resident #45 had a change in condition and was sent to the hospital where he/she was until 5/23/25 with a diagnosis of sepsis, urinary tract infection, and bacteremia. A review of the Urinary/Catheter Care Policy that was given to the surveyor by the Director of Nursing documented #7, ensure drainage bags are not touching the floor. On 6/25/25 at 1:35 PM the Director of Nursing (DON) came to the resident's room with the surveyor. The DON was shown the concern of the bottom of the catheter collection bag and the tubing touching the floor and making the resident more susceptible to infection. The DON confirmed the findings and said they did not change the Foley catheter out after the resident returned from the hospital. The DON also stated that the catheter collection bag should have been in a dignity bag.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility staff failed to assess a resident at risk for malnutrition by the dietitian in a timely manner (Resident #38). This was evident for 1 of 57 residents reviewed during a complaint survey. The findings include: Review of Resident #38's medical record on 6/25/25 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include malnutrition and gastrostomy. Malnutrition is a serious condition that arises from an imbalance in nutrient intake, either a deficiency or excess, or from impaired nutrient utilization. A gastrostomy is a surgically created opening (stoma) in the abdomen, leading directly into the stomach, used for feeding or administering medications. Further review of the Resident's record revealed the Resident was transferred to the hospital on 4/2/25 and returned to the facility 4/18/25, transferred again on 4/20/25 and returned to the facility on 4/22/25. Further review of the Resident's medical record revealed the Resident was not assessed by the Dietitian until 4/25/25. At that time the Resident was documented to be at risk for malnutrition. Interview with the Director of Nursing on 7/1/25 at 7:40 AM stated the expectation is the Resident is to be assessed within the week of admission by the Dietitian and confirmed Resident #38 was not assessed in a timely manner after admission.

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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. Based on observation, interview and medical record review, the facility staff failed to provide respiratory care to meet the needs of a resident (Resident #12). This was evident for 1 of 57 residents reviewed during a complaint survey. The findings include: Observation of Resident #12 on 6/25/25 at 10:10 AM revealed the Resident in bed with oxygen hooked to a humidified bottle that was empty. Interview with the Resident #12 on 6/25/25 at 10:10 AM at that time stated he/she called to be suctioned about 30 minutes prior and it has not been done. The Resident stated a GNA (geriatric nursing assistant) came in the room but a nurse has not been in to suction the Resident. On 6/25/25 at 10:17 AM the Surveyor brought the Director of Nursing (DON) to the Resident's bedside and the DON confirmed the Resident's humdification bottle was empty. The Resident expressed the need to be suctioned and had been waiting for 30 minutes. The DON at that time advised the Unit Manager (Staff #17) the Resident's request to be suctioned. Staff #17 stated she was doing skin assessments but would return. On 6/25/25 at 10:21 AM Staff #17 returned to the Resident bedside to suction the Resident. Review of Resident #12's medical record on 6/25/25 revealed the Resident was admitted to the facility in September 2022 and has a diagnosis to include tracheostomy. A tracheostomy is a surgical procedure that creates an opening in the neck, called a stoma, and inserts a tube into the trachea (windpipe) to facilitate breathing Further review of Resident #12's medical record revealed a physician's order on 6/19/25 of humidified oxygen to trach. Interview with the Director of Nursing on 6/27/25 at 1:45 PM confirmed the facility staff failed to provide respiratory services to meet the needs of Resident #12.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, documentation review, and staff interview, it was determined that the facility failed to post the resident census and total number and actual hours worked by categories of Registered nurses, Licensed practical nurses, and Certified nursing aides at the beginning of the shift. This was evident upon entrance to the facility and on 1 of 1 nursing units observed during a complaint survey. The findings include: On 6/23/25 at 7:30 AM, upon entrance to the facility, observation was made of the facility lobby. There was a staffing schedule posted next to the receptionist window. The date on the schedule was 6/20/25. The schedule had listed all the categories of nursing staff along with the resident census and the total hours worked. The surveyor then walked up to the first floor nurse's station at 7:40 AM and observed the staffing schedule on the counter. The schedule was dated 6/20/25. The staffing coordinator immediately walked up to the surveyor with copies of the nursing staffing for 6/23/25 and stated that she does the schedules and puts them around on all of the nursing units when she gets in. At that time the surveyor informed her that the schedules had not been changed since 6/20/25.

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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. Based on review of complaints, medical record review, and interview, it was determined the facility failed to provide timely medications to meet the needs of the residents. This was evident for 1 (Resident #16) of 57 residents reviewed during a complaint survey. The findings include: On 6/24/25 at 10:22 AM a review of complaint MD00210193 alleged that the facility was always running out of Resident #16's pain medication. Review of Resident #16's medical record revealed Resident #16 was admitted to the facility in May 2021 with diagnoses that included systemic sclerosis with polyneuropathy, acquired absence of right and left leg below the knee, phantom limb syndrome with pain, muscle spasms, type 2 diabetes mellitus with diabetic neuropathy and chronic pain. Systemic sclerosis can be associated with peripheral neuropathy, which affects the peripheral nerves. Review of Resident #16's medications revealed the use of Gabapentin 3 times a day, Methadone 3 times a day, hydromorphone (Dilaudid) every 4 hours as needed for pain, and Acetaminophen every 6 hours as needed for pain. On 6/24/25 at 10:58 AM an interview was conducted with the Assistant Director of Nursing (ADON) regarding Resident #16's pain medications. The ADON stated that the Dilaudid and Methadone were the biggest problems and that there was a problem back in August 2024 where the pharmacy and physicians were not computing the amount of medication that the resident was taking and the pharmacy was sending less that what was being ordered. The ADON stated the problem got solved, however there were still occasions that the facility runs out, but it normally gets resolved within a day. On 7/1/25 at 12:10 PM an interview was conducted with Resident #16. Resident #16 stated, they are out of my Methadone today and I have not received it since last night. This still happens all the time. On 7/1/25 at 12:15 PM an interview was conducted with LPN #33 who stated, it is on its way. There was a hold because the dose was too high. LPN #33 stated that one time the resident ran out of the med, and it was a pharmacy issue. On 7/1/25 at 12:18 PM an interview was conducted with the ADON. The ADON stated, I get a report every morning from the pharmacy if there are issues with a dosage or the way a medication is ordered and Resident #16's name was not on the report this morning. The ADON stated now it is typically an issue with timely reordering. On 7/1/25 at 1:06 PM the ADON stated that the unit manager called the pharmacy because the resident has not had a dosage change and has been on this dosage forever and that the pharmacy flagged it. They sent in the reorder yesterday and the pharmacy flagged for the doses. The ADON stated the medication should have come in on the evening run. There should have been no delay, and the pharmacy should have notified me.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to monitor the blood pressure and heart rate prior to administering a blood pressure medication per physician's orders. This was evident for 3 (#40, #34, 17) of 57 residents reviewed during a complaint survey. The findings include: 1) On 6/25/25 at 7:59 AM a review of Resident #40's medical record was conducted. Review of Resident #40's October 2024 Medication Administration Record (MAR) documented the medication Carvedilol Oral Tablet 25 MG (Carvedilol), give 1 tablet by mouth two times a day for hypertension, Hold for HR (heart rate) less than 50. This order was written on 4/4/24. Review of the October 2024 MAR failed to produce documentation that Resident #40's heart rate was monitored prior to the administration of the medication. Review of the vital sign section of the medical record revealed the heart rates were not being consistently taken at 8 AM and 8 PM. Review of the June 2025 MAR revealed the heart rates were still not being documented. On 7/2/25 at 1:29 PM an interview was conducted with the Director of Nursing (DON). The physician's order for the HR was reviewed with the DON and she was shown that it was not being monitored. The DON confirmed the findings. 2) On 6/25/25 at 11:45 AM a review of Resident #34's medical was conducted. Resident #34 was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included but were not limited to a cerebral infarction (stroke), hypertension, atrial fibrillation, and atherosclerotic heart disease of the native coronary artery. Review of an order written on 4/22/25 documented the medication Hydralazine 50 mg. to be given every 8 hours for hypertension and to hold if SBP (systolic blood pressure which is the top number of the blood pressure reading) was less than 110. Review of Resident #34's April 2025 MAR documented on 4/25/25 at 1400 the blood pressure was 100/62. The medication was given as evidence of the nurse's initials with a check mark in the box. On 7/2/25 at 1:29 PM the DON was interviewed and confirmed the finding. 3) On 6/26/25 at 7:51 AM a review of Resident #17's medical record was conducted. Resident #17 was admitted to the facility in June 2024 from an acute care facility where the resident was treated for 18 days for orthostatic hypotension. Orthostatic hypotension is a condition where the blood pressure drops suddenly when a person stands up from a lying or sitting position. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of June 2024 physician's orders revealed Resident #17 was prescribed the medication Midodrine 5 mg. (2) tablets 3 times a day for hypotension. The order stated to hold the medication if the blood pressure (bp) was greater than 140/90. This order was written from 6/3/24 to 6/21/24. Review of Resident #17's June 2024 Medication Administration Record (MAR) documented the medication was given outside of physician ordered parameters. The medication was given on 6/13/24 at 0600 for bp 145/65, 6/12/24 at 2200 for bp 144/68, and 6/18/24 at 1400 for bp 144/75. The Midodrine order then changed on 6/21/25 and the order was to hold for bp greater than 150/90. Review of Resident #17's June 2024 MAR documented the medication was given on 6/28/24 at 1400 for bp 169/89. This was outside of physician ordered parameters. Review of Resident #17's July 2024 MAR documented the medication was given on 7/15/24 at 1400 with bp 155/81 and on 7/16/24 at 0600 for bp 151/78. On 6/30/25 at 8:30 AM LPN #21 was interviewed and stated if there are initials and a check mark in the box then the medication was given. On 6/30/25 at 12:08 PM an interview was conducted with the Director of Nursing (DON). The DON confirmed the findings.

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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 observation, staff interview, and documentation review it was determined that facility staff failed to 1) keep treatment and medication carts locked when unattended, 2) date medication/biologicals when opened and discard medications/biologicals when expired. This was evident on 2 of 3 nursing units observed during a complaint survey. The findings include: 1) On 6/23/25 at 7:50 AM observation was made of an unlocked and unattended treatment cart on the second-floor nursing unit sitting in an alcove. The surveyor opened the top drawer and observed prescription ointments and creams that include: Ketoconazole cream 2% (3) tubes; Todosorb Gel (2) tubes, Betamethasone Dipropionate, Mupirocin ointment (2) tubes belonging to Resident #42, that was dispensed on 9/7/23, Kiclofenac Sodium Gel (1) tube and one Mupirocin ointment tube that had no cap. Licensed Practical Nurse (LPN) #6 was shown the Mupirocin ointments, and she stated if they were dispensed on 9/7/23 they were no good. LPN #6 was informed that the treatment cart was left unlocked and unattended. LPN #6 locked the treatment cart at that time. 2) On 6/25/25 at 11:42 AM observation was made of an unlocked and unattended medication cart on the first-floor nursing unit sitting outside of room [ROOM NUMBER]. The surveyor opened the top drawer and observed plastic 30 ml. medication cups with pills. One plastic cup had 3 black pills. One medication cup had 2 white pills, 1 round pill, and 1 black and white capsule. One medication cup had 2 white pills sitting inside another medication cup. There were no labels of names on the medication cups. Also observed in the top drawer was Lispro (Humalog) insulin for Resident #56 that was opened on 4/21/25. According to the manufacturer's instructions, the insulin should be discarded 28 days after opening as it may lose its effectiveness. Resident #57's Lantus Solostar injection pen was not dated when it was opened. There was also a Lispro quick pen that had no date and no name that was lying in the top drawer. The other drawers of the medication cart were opened and contained over the counter medications and prescription medications for the residents on the 100 hallway. On 6/26/25 at 11:44 AM LPN #38 walked up to the medication cart and saw the surveyor with the drawers open. LPN #38 stated, I made a mistake. I didn't lock my cart. I'm sorry. At that time the surveyor asked LPN #38 why there were dispensed medications in plastic cups in the top drawer. LPN #38 stated that one of the residents was in therapy and he did not want to waste the medication. LPN #38 could not say why there were 2 other medication cups with pills in them. The surveyor asked LPN #38 about Resident #56's insulin and the date. LPN #38 was asked if he knew when the expiration date was. LPN #38 could not answer that the insulin was only good for 28 days after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Storage of Medications Policy that was given to the surveyor by the Director of Nursing revealed I. General Guidance; 2. only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access. 3. All medications dispensed by the pharmacy are stored in the pharmacy container with the pharmacy label. III. Expiration Date (Beyond-Use Dating) 3. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, and blood sugar testing solutions and strips require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency. 8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining. On 7/2/25 at 1:29 PM the Director of Nursing (DON) was informed of the findings. The DON stated she had been made aware, and they had already started in-servicing staff.

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. Based on review of a complaint, medical record review, and interview, it was determined the facility failed to file in the resident's medical record a signed and dated EKG. This was evident for 1 (Resident #34) of 57 residents reviewed during a complaint survey. The findings include: On 6/25/25 at 11:45 AM a review of complaint MD00217108 was conducted and it was alleged that the facility could not obtain an EKG for Resident #34, and the resident had to be sent out to the emergency room for an EKG. An EKG, also known as an ECG, is a test that records the electrical activity of the heart, helping to detect various heart conditions. Review of Resident #34's medical record revealed on 4/25/25 at 11:11 AM a health status note that documented the nurse spoke with the NP (nurse practitioner) regarding increased heart rate and low-grade fever on the previous shift and new orders were received for a stat (immediate) EKG along with a chest x-ray and urinalysis. The note was written by LPN #17. Further review of Resident #34's medical record failed to produce evidence that an EKG was done. The results tab of the electronic medical record along with the miscellaneous section of the medical record was void of an EKG. On 7/1/25 at 1:45 PM an interview was conducted with LPN #17, the unit manager. LPN #17 showed the surveyor the order for the EKG that was entered on 4/25/25 at 9:22 AM and that the EKG was done at 5:23 PM. When asked where the EKG was in the medical record LPN #17 stated that it was normally downloaded into the miscellaneous section, however someone did not download it and put it in the medical record. On 7/2/25 at 1:29 PM the Director of Nursing (DON) was informed that the EKG was not in the medical record.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 3) The facility failed to obtain a gynecology appointment as requested by the resident. On 6/30/25 at 12:17 PM a review of complaint MD00210037 was conducted. Review of the complaint alleged that the facility failed to arrange and assist Resident #22 to an appointment with the gynecologist. Review of Resident #22's medical record revealed a physician's visit dated 11/22/21 which documented under the diagnosis, assessment and plan, Female perineal bleeding. Suspect vaginal/postmenopausal bleeding from endometrial thickening. Pelvic ultrasound results reviewed. The note documented that the resident would like to follow up with her gynecologist at a specific gynecology clinic. The note concluded, Order to set up appointment with patient's gynecologist placed. Review of physician's orders revealed an order written on 11/22/21 at 10:17 AM that stated to schedule an appointment with the specific name of the gynecology group, along with the phone number for menopausal bleeding, endometrial thickening. Review of the entire medical record failed to produce documentation that the appointment was scheduled. There was no evidence found in the medical record that Resident #22 had ever gone to the appointment. On 7/1/25 at 8:21 AM the Director of Nursing (DON) was interviewed and stated that she had only been at the facility since March 2025. The DON stated she looked through all the documentation and could not find anything about a gynecology appointment. Based on medical record review and interview, the facility staff failed to obtain outside services for residents in a timely manner. This was evident for 3 (Resident #27, #30, #22) of 57 residents reviewed during a complaint survey. The findings include: 1. The facility staff failed to ensure Resident #27 was sent to the stroke clinic. Review of Resident #27's medical record on 6/25/25 revealed the Resident was admitted to the facility in September 2024 from the hospital with a diagnosis to include intracerebral hemorrhage. Intracerebral hemorrhage (ICH) is a type of stroke where bleeding occurs directly into the brain tissue. Review of Resident #27's hospital discharge instructions revealed the Resident was to follow up with Neurology Stroke Clinic. Further review of the Resident's medical record revealed a physician order on 11/21/24 a physician order for the Resident to go to the stroke clinic on 12/6/24. Further review of the Resident's medical record revealed no evidence the facility staff sent the Resident to the stroke clinic on 12/6/24. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with Resident #27's representative on 7/1/25 at 8:25 AM, the representative stated the facility staff canceled the appointment at the stroke clinic even after a family member took off work to attend the appointment. Interview with the Director of Nursing on 7/2/25 at 7:40 AM confirmed the Resident did not go to the stroke clinic on 12/6/24. 2. The facility staff failed to ensure Resident #30 was scheduled to go to orthopedic follow up appointment. Review of Resident #30's medical record on 6/25/25 revealed the Resident was admitted to the facility for rehabilitation in January 2024 from the hospital following an orthopedic surgery. Review of the hospital discharge instructions revealed the Resident was to follow up with the Orthopedic Surgery Service within 2 months. Further review of the Resident's medical record revealed the Resident was not scheduled or seen by the Orthopedic Surgery Service prior to discharge in April 2024. Review of the Discharge Instructions/Post Discharge Plan of Care documented on 4/4/25 revealed there is no documentation to follow up with Orthopedic Surgery Services or a scheduled appointment. Interview with the Director of Nursing on 6/30/25 at 2:10 PM confirmed Resident #30 was not seen by the Orthopedic Surgery Service prior to discharge from the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 (Resident #12, #35) of 57 residents reviewed during a complaint survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1. Review of Resident #12's medical record on 6/25/25 revealed the Resident was admitted to the facility in September 2022 with a diagnosis to include Tinea Unguium. Tinea unguium, also known as onychomycosis, is a fungal infection that affects the nails, typically the toenails. It causes the nails to become thickened, discolored, brittle, and may separate from the nail bed. Observation of Resident #12's feet with the Director of Nursing on 6/25/25 at 10:17 AM revealed elongated, thickened toenails and dry, cracked skin. Further review of Resident #12's medical record revealed the last podiatrist visit documented in the medical record was 1/16/24. During interview with the AIT (Administrator in Training) on 6/26/25 at 7:30 AM, the AIT gave the Surveyor podiatry notes from 9/1/24, 12/10/24, 1/14/25 and 6/8/25. At that time the AIT stated the podiatry notes were not in the Resident's medical record and had to be obtained from the Podiatrist's office. Interview with the Director of Nursing on 6/27/25 at 1:45 PM confirmed Resident #12's medical record did not include the podiatry notes from 9/1/24, 12/10/24, 1/14/25 and 6/8/25. 2. Review of Resident #35's medical record on 6/25/25 revealed the Resident was admitted to the facility on [DATE] for rehabilitation following an orthopedic procedure. Further review of Resident #35's medical record revealed the Resident went to an orthopedic follow up appointment on 5/9/25. Review of the Resident's medical record revealed there was no report of the orthopedic appointment to include findings and recommendations. Interview with the Director of Nursing on 6/26/25 at 2:15 PM confirmed Resident #35's medical record did not include the consult from the orthopedic follow up on 5/9/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215269	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkton Nursing and Rehabilitation Center	1 Price Drive Elkton, MD 21921

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interviews, and documentation review, it was determined the facility failed to have an effective pest control program as evidenced by numerous flies and gnats seen throughout the facility. This was evident on 2 of 3 nursing units, in resident rooms, the kitchen, the rehab gym, and the conference room during a complaint survey. The findings include: On 6/23/25 at 8:00 AM to 7/2/25 observation was made in the conference room where the surveyors were stationed for the week of flies and gnats consistently flying around the room. Throughout the survey from 6/23/25 to 7/2/25 there were flies and gnats observed in the first-floor hallways and resident rooms. On 6/24/25 at 1:45 PM an interview was conducted with the resident in room [ROOM NUMBER] who stated there have been flies in his/her room for at least a week and that they were annoying. On 6/25/25 at 10:17 AM there was a fly on Resident #12 while lying in bed with the Director of Nursing present. On 6/26/25 at 12:00 PM flies were observed in unit 1, the rehab hallway and in the kitchen. In the kitchen flies were observed on the storage racks and flying around the serving table while the food was being plated. Staff #23 stated, now that the change in weather has occurred we have flies. On 6/30/25 at 8:19 AM an interview was conducted with the Director of Maintenance. He stated that there have been fly lights up in the hallways and kitchen for the past 2 years. Pest control comes out and sprays and puts chemicals in the drains. In the beginning of summer, it is really tough, and it breaks by the middle of July. On 7/1/25 at 8:51 AM there was a fly in the therapy gym. Review of Pest control invoices documented that the pest control company came to the facility approximately twice a month. The surveyor received invoices dated 5/17/25, 4/25/25, 4/3/25, 3/20/25, and 3/7/25. On 7/2/25 at 1:00 PM the Nursing Home Administrator (NHA) was interviewed and stated that they were going to be more proactive with the fly problem since they know when the problem usually begins at the beginning of summer.