| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215269 | A. Building<br>B. Wing | 01/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Elkton Nursing and Rehabilitation Center | 1 Price Drive<br>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.

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>Based on medical record review and staff interview, it was determined that the facility staff failed to administer medications as ordered by the physician (Resident #302). This was evident for 1 of 5 residents reviewed during a complaint survey.The findings include:Review of Resident #302's medical record on 1/29/26 revealed the Resident was admitted to the facility with a diagnosis to include pneumonia.Review of Resident #302's January 2026 Medication Administration Record with the Director of Nursing on 1/29/26 revealed no documentation the following medications and treatments were administered to the Resident per physician's orders:PICC (peripherally inserted central catheter) line flush every shift on 1/7/26 night shift and 1/10/26 day shiftAcetylcysteine Solution 10 ml inhale orally every 6 hours on 1/8, 1/9 and 1/10/26 at 6 AM, 1/11/26 at 12 PM and 6 PM and 1/12/26 at 6 PMAlbuterol Sulfate Inhalation 3 ml via nebulizer every 6 hours on 1/8, 1/9 and 1/10/26 at 6 AMPiperacillin 4.5 gram intravenously every 6 hours for pneumonia on 1/8, 1/9 and 1/10/26 at 6 AMInterview with the Director of Nursing on 1/29/26 at 10:28 AM confirmed the Surveyor's findings. |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**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 provide treatment/services to prevent/heal pressures ulcers. This was evident for 1 (#300) 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). On 1/29/26 at 8:35 AM a review of Resident #300's medical revealed the resident was admitted to the facility on [DATE] with diagnoses that included a fracture of the left pubis, type 2 diabetes mellitus with diabetic neuropathy and hyperglycemia, and severe protein-calorie malnutrition. Review of a 1/6/26 nursing admission note documented Resident #300 was admitted with a pressure ulcer on the right heel. A 1/6/26 medical progress note documented that Resident #300 had an active right heel pressure injury and staff were to, offload right heel continuously with boots and pillows and avoid pressure on affected area. A 1/8/26 skin and wound note documented the right heel pressure ulcer was stage 3 and the assessment/plan was, float heels while in bed with use of the facility's preferred equipment, pillows/boots, etc. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels. Review of Resident #300's January 2026 Treatment Administration Record (TAR) documented the physician's order, offload heels with green boots as tolerated every shift. On 1/28/26 the boots were signed off as worn each shift. On 1/29/26 at 8:50 AM Resident #300 was observed in bed lying on his/her back eating breakfast. Resident #300's feet were observed lying directly on the mattress of the bed and the heels were not elevated. Resident #300 was wearing gray slipper socks and did not have heel boots on their feet. Resident #300 was asked if the staff ever elevated his/her feet off the mattress and the response was, sometimes but there is nothing there now. On 1/29/26 at 9:30 AM a second observation was made of Resident #300, and his/her heels were still lying directly on the mattress. On 1/29/26 at 11:04 AM a third observation was made of the resident, and a pillow was under the bottom of his/her legs. Resident #300 was wearing gray slipper socks. The Director of Nursing (DON) came to the room with the surveyor and observed the resident's feet. The DON was informed of the previous observations and was informed that nursing staff had been signing off that heel boots were being worn, however there were no heel boots in the resident's room. The DON confirmed the finding and stated she would have someone get heel boots on the resident. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, it was determined the facility staff failed to ensure interventions for safety were in place for a resident with a history of falls. This was evident for 1 (#300) of 3 residents reviewed during a complaint survey.The findings include: On 1/29/26 at 8:35 AM a review of Resident #300's medical revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, a fracture of the left pubis, diabetes mellitus with diabetic neuropathy and hyperglycemia, altered mental status, severe protein-calorie malnutrition, anemia, and orthostatic hypotension. Review of a 1/6/26 nursing admission note documented that Resident #300 was alert and oriented times 2. Review of a 1/6/26 medical progress note documented that Resident #300 had a recent hospitalization from 12/9/25 to 1/6/26 for acute metabolic encephalopathy, infection, and acute kidney injury. The note documented that the resident arrived at the hospital alert and oriented times 2 and had some confusion. The note documented that Resident #300 had a recent fall at rehabilitation that resulted in a head injury. The resident reported a severe concussion with transient loss of consciousness and significant memory impairment. The note documented that the resident reported inability to walk, intermittent difficulty speaking, left eye visual loss, and poor appetite. The note documented that Resident #300 had, significant deconditioning impaired mobility, chronic pain, orthostatic hypotension, nutritional deficits, and high fall risk and was admitted to subacute rehabilitation for continued physical therapy, occupational therapy, nutritional optimization, pain management, and medical monitoring prior to safe long-term disposition. Review of a 1/9/26 at 17:36 (5:36 PM) change in condition note documented Resident #300 had a fall and was transported out of the facility to the hospital. A 1/9/26 at 18:18 health note documented that Resident #300 had an unwitnessed fall out of bed. The resident reported that he/she hit his/her head and was receiving the blood thinner Eliquis twice a day. The nurse reported that the resident had altered mental status and increased aggression that was not at the resident's baseline. A 1/10/26, 72-hour post fall documentation of note documented the resident was back in the facility and interventions were currently in place to prevent additional falls such as the bed in low position and the call light within reach. A 1/13/26 medical progress note documented the visit was a follow-up for a recent fall with head strike, right heel ulcer care, pain control, glucose trends and blood pressure variability. The note documented, the patient appears alert but disorganized, with tangential speech during interview. [He/she] is disoriented to time, unable to accurately state the current date, month, or year, and believes the year is 2000. The note documented, recent head injury after unwitnessed fall on anticoagulation: maintain fall precautions with environment optimization including keeping urinal and call bell within reach. Orthostatic hypotension with variable BP (blood pressure) on midodrine/fludrocortisone. Continue holding midodrine parameters and avoid evening doses to reduce supine hypertension, monitor BP trends symptoms and volume status. The medication Midodrine is used to treat symptomatic orthostatic hypotension (sudden blood pressure drop upon standing). It works by constricting blood vessels to increase blood pressure, reducing dizziness, lightheadedness, and fainting.On 1/14/26 a change in condition note documented the resident had a fall after an episode of combative and agitated behavior. Resident #300 was sent to the hospital and returned to the facility on 1/27/26. On 1/29/26 at 8:50 AM observation was made of Resident #300 lying on his back in bed eating breakfast. The resident's call bell was observed lying under the bed and not within reach. The resident's urinal was hanging off the second drawer handle of the night stand which was not within reach and was at least 4 feet away from the right side of the bed. There were no fall mats next to the bed. On<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1/29/26 at 8:50 AM an interview was conducted with Resident #300. Resident #300 stated that he/she had trouble standing up. Resident #300 stated he/she had fallen and broke his/her pelvis and sternum. Resident #300 stated he/she had 2 cracks in his/her skull because he/she fell and went unconscious. On 1/29/26 at 8:50 AM Licensed Practical Nurse (LPN) #23 was asked to come into Resident #300's room. At that time the surveyor showed LPN #23 where the call bell was located. LPN #23 stated, what is it doing under there. LPN #23 picked up the call bell and was holding the end of it and said, I don't know who was supposed to put it on the bed. At that time the surveyor showed LPN #23 where the urinal was and that the resident could not reach it.Continued review of Resident #300's medical record revealed a care plan, the resident is at risk for falls and fall related injury r/t weakness, diabetes, orthostatic hypotension, pain in left hip, anemia, use of cardiovascular and psychotropic medications. Interventions on the care plan included, Ensure urinal is within reach, place bed in lowest position while resident is in bed, place common items within reach of the resident, and remind the resident to use their call light to ask for assistance with ADLS.Review of physician's orders revealed the order for Midodrine 10 mg. to be given 3 times a day for hypotension. The order stated if the systolic blood pressure (SBP) (top number of blood pressure) is greater than 120, the medication should be held. Review of Resident #300's January 2026 Medication Administration Record (MAR) documented the Midodrine was given on 1/28/26 at 1400 (2 PM) for a blood pressure of 128/74. The Midodrine should have been held because it was outside of physician ordered parameters. Cross Reference F757.On 1/29/26 at 11:08 AM with the Director of Nursing (DON), Resident #300 was observed with the bed in medium high position. The DON confirmed the bed was not in low position. The DON via bed remote lowered the resident's bed. The DON was asked if Resident #300 should have fall mats next to the bed. The DON stated it depended on what therapy assessed as the resident just came back from the hospital. The DON was informed at that time about the Midodrine being given outside of parameters. The DON stated, I just saw that when you asked about it. The DON was also informed of the morning's observations of the urinal on the night stand drawer handle and the call bell under the bed.On 1/29/26 at 11:37 AM an interview was conducted with Occupational Therapist (OT) #21. OT #21 stated that Resident #300 was a fall's risk. OT #21 stated that when she saw Resident #300 this morning that Resident #300 was a little more sedated than yesterday. Prior to going out to the hospital the resident had a urinary tract infection and then had the behaviors and altered mental status and had previous falls. I feel like fall mats are a good idea. OT #21 stated that she felt that when the resident's underlying medical conditions arise then it places the resident at more of a risk for falls. OT #21 stated that Resident #300 was also impulsive, so if Resident #300 could not reach things the resident would try to get out of bed which the resident knew was not safe to do.On 1/29/26 at 1:15 PM an interview conducted with the medical director confirmed that the Midodrine should have been held. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**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 follow physician ordered parameters when administering blood pressure medications. This was evident for 3 (#300, #304, #303) of 3 residents reviewed during a complaint survey. The findings include: 1) On 1/29/26 at 8:35 AM a review of Resident #300's medical revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, a fracture of the left pubis, diabetes mellitus with diabetic neuropathy and hyperglycemia, anemia, and orthostatic hypotension. Review of a 1/6/26 medical progress note documented that Resident #300 had a recent hospitalization from 12/9/25 to 1/6/26 for acute metabolic encephalopathy, infection, and acute kidney injury. The note documented that Resident #300 had, significant deconditioning impaired mobility, chronic pain, orthostatic hypotension, nutritional deficits, and high fall risk and was admitted to subacute rehabilitation for continued physical therapy, occupational therapy, nutritional optimization, pain management, and medical monitoring prior to safe long-term disposition. A 1/13/26 medical progress note documented the visit was a follow-up for a recent fall with head strike, right heel ulcer care, pain control, glucose trends and blood pressure variability. The note documented, recent head injury after unwitnessed fall on anticoagulation: maintain fall precautions with environment optimization including keeping urinal and call bell within reach. Orthostatic hypotension with variable BP (blood pressure) on midodrine/fludrocortisone. Continue holding midodrine parameters and avoid evening doses to reduce supine hypertension, monitor BP trends symptoms and volume status. The medication Midodrine is used to treat symptomatic orthostatic hypotension (sudden blood pressure drop upon standing). It works by constricting blood vessels to increase blood pressure, reducing dizziness, lightheadedness, and fainting.Review of January 2026 physician's orders for Resident #300 revealed the order for Midodrine 5 MG, give 3 tablets by mouth three times a day for hypotension (low blood pressure); hold for systolic blood pressure (SBP) greater than 120. SBP is the top number of the blood pressure reading. This was ordered on the day of admission, 1/6/26.Review of Resident #300's January 2026 Medication Administration Record (MAR) documented the Midodrine was given on the following days when outside of physician ordered parameters:1/6/26 at 6 AM for b/p 132/881/9/26 at 12PM for b/p 128/661/14/26 at 4 PM for b/p 122/68 Furthermore, on 1/11/26 at 6 AM the blood pressure was 118/69 and the Midodrine was held. The Midodrine should not have been held because the SBP was below 120.On 1/14/26 Resident #300 was sent to the hospital for a fall and returned to the facility on 1/27/26. After Resident #300 returned from the hospital the Midodrine order was changed to 10 mg. three times per day for hypotension. Hold if SBP is greater than 120.Review of the January 2026 MAR documented the Midodrine was given on 1/28/26 at 2 PM for a b/p of 128/74. The Midodrine should have been held per physician ordered parameters.On 1/29/26 at 10:00 AM the surveyor requested a list of all residents on Midodrine.On 1/29/26 at 11:08 AM the Director of Nursing (DON) was informed about the Midodrine being given outside of parameters. The DON stated, I just saw that when you asked about it. 2) Review of Resident #304's medical record revealed physician's orders for Midodrine 5 mg., give 1 tablet by mouth one time a day for hypotension: Hold for SBP greater than 120.Review of Resident #304's December 2025 MAR documented the Midodrine was given on the following days when outside of physician ordered parameters: 12/01/25: 121/6812/14/25: 166/8412/15/25: 132/7112/17/25: 126/7212/20/25: 121/7112/22/25: 134/6012/23/25: 121/7112/29/25: 126/7612/31/25: 132/78 Review of Resident #304's January 2026 MAR documented the Midodrine was given on the following days when outside of physician ordered parameters: 1/10/26: 134/551/11/26: 123/621/27/26: 132/74 3) Review of Resident #303's medical<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | record revealed a physician's order for Midodrine 5 mg., give 1 tablet by mouth 3 times a day for hypotension. Hold for SBP greater than 110. Review of Resident #303's December 2025 MAR documented the Midodrine was given on the following days when outside of physician ordered parameters:12/04/25: 121/62 at 12 PM12/04/25: 119/72 at 6 PM12/09/25: 132/77 at 6 PM12/13/25: 126/72 at 6 AM12/14/25: 118/60 at 6 AM12/14/25: 112/70 at 6 PM12/15/25: 118/68 at 12 PM12/16/25: 120/61 at 6 PM12/28/25: 118/73 at 2 PM12/31/25: 126/78 at 6 AM12/31/25: 119/78 at 8 PM Review of Resident #303's January 2026 MAR documented the Midodrine was given on the following days when outside of physician ordered parameters:1/04/26: 125/74 at 6 AM1/09/26: 122/74 at 6 AM1/06/26: 118/74 at 2 PM1/06/26: 121/77 at 8 PM1/11/26: 115/72 at 8 PM1/25/26: 113/65 at 6 AM1/25/26: 119/741/27/26: 118/70 at 6 AM On 1/4/26 at 8 PM the resident's blood pressure was 97/58 and staff did not administer the Midodrine when they should have administered as the SBP was below 110. On 1/29/26 at 1:15 PM an interview was conducted with the medical director who confirmed that facility staff failed to follow the physician's ordered parameters. The medical director stated that he had concerns when the medication was administered outside of parameters.On 1/29/26 at 1:30 PM the concern was discussed with the DON who stated that she would begin in-servicing staff. |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>Based on medical record review and staff interview, it was determined that the facility staff failed to obtain laboratory tests as ordered by the physician for residents (#300 and #302). This was evident for 2 of 3 residents reviewed for laboratory services during a complaint survey.The findings include: 1. Review of Resident #300's medical record on 1/29/26 revealed the Resident was admitted to the facility in January 2026 with diagnosis to include diabetes and anemia. Review of Resident #300's physician orders revealed the Resident was ordered a CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel) and Magnesium level on 1/5/26 to be completed on 1/6/26. Further review of Resident #300's medical record on 1/29/26 revealed the Resident did not have any laboratory results on 1/6/26. Review of the Resident's nurses' notes revealed no documentation on why the laboratory tests were not completed. Interview with the Director of Nursing on 1/29/26 at 1:45 PM confirmed the facility staff failed to obtain laboratory tests ordered by the physician on 1/5/26 for Resident #300. 2. Review of Resident #302's medical record on 1/29/26 revealed the Resident was admitted to the facility with a diagnosis to include pneumonia. Further review of Resident #302's medical record revealed the Resident was seen by the Physician's Assistant (Staff #24) on 1/7/26 for abnormal laboratory results. At that time Staff #24 documented to repeat CBC (Complete Blood Count) in the AM. Further review of Resident #302's medical record revealed a nurse's note by Staff #25 on 1/7/26 at 10:57 PM that stated: Labs from 1/7/26 reviewed by PA (Staff #25) resident already has order for CBC in am. Review of Resident #302's laboratory results revealed no lab tests were drawn on 1/8/26. The Resident was discharged from the facility on 1/13/26 without the lab tests completed. Interview with the Director of Nursing on 1/29/26 at 10:28 AM confirmed Resident #302 did not have a CBC laboratory test on 1/8/26 as ordered by the physician. |