| 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 | 06/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on interview, record review, and staff interview, it was determined that the facility failed to notify Resident #1's emergency contact representative and physician in a timely manner after a significant change in condition related to a fall. This was evident for 1 (Resident #1) of 1 residents reviewed for falls during the survey. The findings include:On 06/16/2026 at 10:25 AM, during an interview, Resident #1's complainant reported dissatisfaction regarding an incident where the resident was dropped during a transfer from bed to wheelchair that occurred in the early afternoon of 06/14/2026. Resident #1's complainant was frustrated that notification of the fall was delayed until 06/15/2026 at approximately 3:30 AM, when the resident was sent to the emergency room (ER).On 06/16/2026 at 9:31 AM, a review of Resident #1's progress notes revealed a change in condition dated 06/15/2026 at 8:03 AM. Following a fall during a transfer on 06/14/2026 at 11:30 AM, Resident #1 presented with a swollen, warm left leg and reported pain at a level of 10/10. Further review of Resident #1's medical record showed an eINTERACT Transfer Form dated 06/15/2026 at 3:24 AM that indicated notification to the physician and emergency contact for Resident #1 did not occur until approximately 16 hours after the fall.On 06/16/2026 at 2:38 PM, during an interview with the Director of Nursing (DON), a delay in notifying the physician and emergency contact following Resident #1's fall was confirmed. The DON verified that nurses are responsible for these notifications after post-falls. The concern was shared at this time. |

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 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interview, it was determined that the facility failed to have prevent involuntary seclusion. This was evident for three (Resident #2, Resident #7 and Resident #8 ) out of three residents reviewed during the survey.The findings include:Involuntary seclusion is defined as separation of a resident from other residents or from his/her room, or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident representative.MDS (Minimum Data Set) is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions.BIMS (Basic Inventory of Mental Status) is a structured assessment tool aimed at evaluating cognition of the elderly. A BIMS score of 0-7 is reflective of severe cognitive deficit, a score of 8-12 reflects a moderate cognition deficit and a score of 13-15 score is reflective of normal cognition.1). Resident #2 was admitted on [DATE] with diagnoses including but not limited to, respiratory failure with hypoxia and bipolar disorder.During an interview on 6/16/26 at 8:40 AM, NHA (Nursing Home Administrator) #1 stated, I don't believe there is a policy for determining who gets the code to the door on 2 West.A review of Resident #2's medical record on 6/16/26 at 10:50 AM revealed an admission Nursing Collection Tool note written by LPN (Licensed Practical Nurse) #5 on 5/29/26 at 6:33 PM stated, Cognitive state on arrival: Cognitively intact, oriented to person, oriented to place, oriented to time. Further review revealed a Health Status Note written by LPN #5 on 5/30/26 at 3:21 AM that stated, .Resident arrived alert and responsive, able to make needs known.A review of the facility's investigation file for the fall that is mentioned in complaint # 3030738 on 6/16/26 at 12:15 PM revealed that the fall occurred in close proximity to the unit's secured doors. Ongoing review of Resident #2's EMR (electronic medical record) revealed a progress note by APN (Advanced Practice Nurse) #8 that stated, .History of Present Illness: 72 yo (year old) female.was attempting to elope from the facility and was trying to get out the door when she fell backward hitting her head on the ground. She sustained a hematoma to the back of her head and was unable to get up off the ground due to low back pain.A review of complaint #3030738 documented that Resident #2 stated that a nurse at the nursing home.would not let her leave (the unit).During an interview on 6/16/26 at 2:03 PM, DON (Director of Nursing) #2 stated that nursing unit 2 [NAME] is where the dementia residents reside but it is not a certified dementia unit. There are residents on that unit who do not carry the diagnosis of dementia. It is a secure unit. Anyone who is alert and oriented gets the code for the doors to the unit (2 West). Of course, if they are an elopement risk, they don't get the code. [Resident #2] was only in the facility for less than 24 hours so we did not do an elopement evaluation on her prior to the fall.During a telephone interview on 6/17/26 at 9:46 AM, RN (Registered Nurse)#6 stated, To the best of my knowledge, most of the residents (on 2 West) are confused. I cannot say which ones are allowed to have the code to the door.No, there is no list (of residents who have the door code) that I am aware of. If a resident tries to get out, we just redirect them. The code to get out of the unit is different from the code to get in the unit.During a telephone interview on 6/17/26 at 9:55 AM, LPN #5 stated, .You need the code to get out of the unit (2 West). Residents on the unit usually do not have the code to leave the unit. Depending on their evaluation, the residents are determined if they are eligible to have the code. I believe MDS Coordinators evaluate their eligibility. It is not the floor nurse who does that. I am not sure where it is documented that the resident has been given the door code.I have seen residents that have been given the code to leave the unit. Leave the unit to go smoke or whatever after punching the code in.During an interview on 6/17/26 at 11:08 AM, LPN #4 stated, We assess the residents to determine if they can leave the unit. We look at the BIMS score. But you can usually tell after a conversation with the resident. No, there is not a list of the residents that are allowed to leave the unit alone. I don't think it is written down anywhere. LPN #9 and I are here all the<br>(continued on next page) |

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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | time (weekdays) so we know who can go and who cannot. To be honest, most of the oriented residents don't want the code. It is just something else to remember and they know that we will let them out. On weekends, a lot of the staff are agency (nurses who do not work for the facility) and they would not know who is allowed to leave independently, so they don't let the residents out. If a resident is admitted on a weekend and does not get assessed, they are not allowed off the unit until Monday when they are assessed.2). Resident #7 was admitted to the facility on [DATE] with diagnoses that include, but not limited to heart failure and cirrhosis. A review of Resident #7's EMR revealed a quarterly MDS with ARD (Assessment Reference Date) dated 4/14/26 with a documented BIMS score of 15. Resident #7's EMR also contained an Elopement Risk Tool dated 4/23/26 with a score of 1.0 and stated Resident #7 was a low elopement risk.During an interview on 6/17/26 at 10:20 AM, Resident #7 stated, No, I have never been given the door code. I have to get someone to let me out the doors when I want to go to activities.3). Resident #8 was admitted on [DATE] with diagnosis including but not limited to, bipolar disorder.A review of Resident #8's EMR revealed an annual MDS with ARD dated 3/24/26 with a documented BIMS score of 15 . Resident #8's EMR also contained an Elopement Risk Tool dated 6/21/26 with a score of 0.0 and stated Resident #8 was a low elopement risk.During an interview on 6/17/26 at 10:30 Am, Resident #8 stated that she/he did not have the code to the unit door and she/he had to ask staff to let her/him out if she/he wanted to leave the unit. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on review of medical records, observation, and interviews with residents and staff, it was determined the facility failed to report an allegation of resident neglect. This was evident for 1 (Resident #1) of 1 residents reviewed for neglect during the survey. The findings include: The Office of Health Care Quality (OHCQ), an agency within the Maryland Department of Health, monitors care quality in Maryland's health care facilities and community-based programs. Allegations of abuse, neglect, or property misappropriation must be reported to OHCQ. Neglect, is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.On 06/16/2026 at 9:22 AM, a review of Resident #1's care plan (created 08/08/2023; revised 01/17/2024) revealed activity of daily living (ADL) assistance was required due to slurred speech, unsteady gait, history of CVA, stroke, falls, syncope, and weakness. Resident #1's care plan included a 2-person assist mechanical lift transfer intervention (created 08/22/2023; revised 04/11/2025).On 06/16/2026 at 9:00 AM during an observation/interview, Resident #1 was observed with a flaccid left side and reported a concern of being dropped by two aides during a bed-to-wheelchair pivot transfer. The resident stated a Hoyer lift should have been used and complained of left knee pain.On 06/16/2026 at 9:31 AM, a review of Resident #1's progress notes revealed a change in condition dated 06/15/2026 at 8:03 AM. Resident #1 reported 10/10 pain and a swollen, warm left leg following a fall during a bed-to-chair transfer on the day shift. On 06/16/2026 at 12:35 PM, a review of the facility investigation forms revealed 2 written statements from Geriatric Nursing Assistant's (GNA) Staff #7 and Staff #3 regarding Resident #1's transfer that resulted in a fall on 06/14/2026 at 11:30 AM. Staff #7 reported that because Hoyer lift batteries were uncharged, they attempted a standing pivot transfer, during which Resident #1's left leg gave out, resulting in pain to Resident #1's left leg. Staff #3 stated she was told by Staff #7 that there were no hoyer lifts available and felt uncomfortable with the pivot transfer since Resident #1 could not stand. Resident #1 fell during the transfer and was returned to bed using a Hoyer lift and pad.On 06/16/2026 at 2:38 PM, during an interview with the Director of Nursing (DON), it was explained that staff must follow care plans and the Kardex for transfer protocols, such as using a Hoyer lift for Resident #1. Although Staff #7 and Staff #3 were aware of this requirement, they failed to comply, leading to Staff #7's suspension pending investigation. The DON confirmed this failure to follow the plan of care constituted neglect and was a reportable occurrence. However, the DON acknowledged that these specifics regarding Resident #1 were not reported to the Office of Health Care Quality (OHCQ). |

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| F 0689<br><br>Level of Harm - 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>Based on observation, interviews, review of facility documents, and record reviews, it was determined that the facility failed to provide interventions consistent with the resident's needs and professional standards of practice, causing an accident that led to severe pain and an emergency room (ER) transfer. This was evident for 1 (Resident #1) of 3 residents reviewed for falls during the complaint survey. This resulted in actual harm to Resident #1. The findings include:Activities of Daily Living (ADLs) is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, toileting, transferring, and mobility.A pain scale is a 0-10 numerical tool for assessing pain severity, with zero representing no pain and 10 the worst pain imaginable. According to the Mayo Clinic, pain scores from 1-3 are mild, 4-6 are moderate, and 7-10 are severe.On 06/16/2026 at 9:00 AM during an observation/interview, Resident #1 was observed with a flaccid left side and reported a concern of being dropped by two aides during a bed-to-wheelchair pivot transfer. The resident stated a Hoyer lift should have been used and complained of left knee pain.On 06/16/2026 at 10:25 AM, during an interview, Resident #1's complainant reported dissatisfaction regarding an incident where the resident was dropped during a transfer from bed to wheelchair. The complainant noted that staff failed to utilize a Hoyer lift for the transfer because the equipment could not be located at the time.On 06/16/2026 at 9:22 AM, a review of Resident #1's care plan (created 08/08/2023; revised 01/17/2024) revealed activity of daily living (ADL) assistance was required due to slurred speech, unsteady gait, history of CVA, stroke, falls, syncope, and weakness. Resident #1's care plan included a 2-person assist mechanical lift transfer intervention (created 08/22/2023; revised 04/11/2025).On 06/16/2026 at 8:50 AM, a review of Intake #3043744 revealed that the facility called 911 at 3:30 AM, 15 hours after Resident #1 was allegedly dropped by staff who refused to use a Hoyer lift around noon the previous day. Resident #1 claimed an aide told her, Do not say anything; I will be fired, and reported that the facility denied his/her requests for an X-ray or transport. Resident #1, who is unable to use his/her left side, noted it was the third time he/she had been dropped by staff at this facility.On 06/16/2026 at 12:35 PM, a review of the facility investigation forms revealed 2 written statements from Geriatric Nursing Assistant's (GNA) Staff #7 and Staff #3 regarding Resident #1's transfer that resulted in a fall on 06/14/2026 at 11:30 AM. Staff #7 reported that because Hoyer lift batteries were uncharged, they attempted a standing pivot transfer, during which Resident #1's left leg gave out, resulting in pain to Resident #1's left leg. Staff #3 stated she was told by Staff #7 that there were no hoyer lifts available and felt uncomfortable with the pivot transfer since Resident #1 could not stand. Resident #1 fell during the transfer and was returned to bed using a Hoyer lift and pad.On 06/16/2026 at 9:31 AM, review of Resident #1's medical record revealed a change in condition dated 06/15/2026 at 3:20 AM that indicated Resident #1 reported 10/10 left leg pain after falling on her knees during a bed-to-chair transfer. A physician recommended as-needed Tylenol and an ER evaluation. Further review of Resident #1's medical record revealed a physician progress note dated 06/15/2026 at 4:36 AM detailing acute pain after being dropped during a transfer without a Hoyer lift. Assessment noted 10/10 left knee pain, limb-length swelling, a bluish foot with no palpable pulse, and warmth to the touch.On 06/16/2026 at approximately 9:40 AM, a review of Resident #1's progress notes dated 06/15/2026 at 11:46 PM revealed Resident #1 returned from the ER at 10:20 AM with two attendants. Resident #1 reported 3/10 left knee pain and noted receiving pain medication at the hospital.On 06/17/2026 at 12:44 PM, a review of Resident #1's June 2026 pain summary indicated pain scores were consistently 0 until the fall on 06/14/2026. Subsequently, a review of Resident #1's post-fall documentation indicated pain scores rose to 1-10 with persistent left knee pain.On 06/17/2026 at approximately 12:50 PM, a continued review of Resident #1's medical record revealed a medical note from 06/17/2026 at 12:25 PM: Seen today for pain management after a recent fall with left knee/leg<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | pain, detailing new routine orders for oxycodone 5 mg, a 5% lidocaine patch, and Tylenol 1000 mg for pain management. Further review of Resident #1's medication administration record (MAR) confirmed Resident #1 did not require or receive any pain medications for left knee pain in June prior to the fall.On 06/16/2026 at 2:38 PM, during an interview with the Director of Nursing (DON), transfer protocols were discussed, explaining that staff determine a resident's transfer status by reviewing the care plan and referring to the Kardex. The DON stated her expectation that staff adhere to these designated statuses, such as the use of a Hoyer lift. It was confirmed that Staff #7 and Staff #3 were both aware that Resident #1 required a Hoyer lift for transfers. The concern was shared at this time. |