

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Elkton Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to choose his or her attending physician. Based on record review and interview, it was determined that the facility failed to allow residents the right to choose their attending physician. This was evident for thirteen (Residents #2, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #21, and #24) of the fourteen residents interviewed regarding this change. The findings include: Facility admission Packet (page 7)- 4. Your Rights as a Resident- As a resident of this Facility, you have many rights under Federal and State law. Some of those rights are listed in this section. You will be given a written description of all your rights. B Selection of a Doctor or Other Provider- You may select your own doctor and other health care providers. Your doctor and other health care providers must follow our policies. If your doctor and other health care providers do not follow facility policies and procedures, the Facility will ask you to choose other providers. On 7/14/26 at 10:40 AM, the surveyor reviewed complaints [IQIES #3051803 and IQIES #3075025] in which the central issue was the facility changing the attending physician team without allowing the residents to choose their attending physician. During an interview on 7/15/26 at 2:03 PM, SW#10 (social worker) stated, I gave the letter (about the change in physicians happening on July 9th) that the NHA wrote to the residents. If they (the residents) have a low BIMS, I mailed or emailed it to their representative. I never gave the residents any further paperwork. I wrote exactly what was in the NHA letter in my notes (in the EMR) on 6/12/26. There is only one attending in the facility now [MD #23] and his NP. They are here everyday which is way more than the other group. The residents really don't have a choice since there is only one doctor in the building. During an interview on 7/15/26 at 1:40 PM, Resident #12 stated, I would rather have stayed with [MD # 7]. Bottom line- I would like to have [MD #7]. During an interview on 7/15/26 at 1:45 PM, Resident #13 stated, No one asked me my permission about changing my doctor. I would want to keep [MD #8]. I don't know my new doctor's name or how to get in touch with him. During an interview on 7/15/26 at 2:25 PM, Resident #10 stated, No, I did not want to change doctors. I want [MD #5] back. I have known him for years. He treats me well. During an interview on 7/15/26 at 2:30 PM, Resident #11 stated, I would rather stay with my old doctor [MD # 8] and his/her NP. I never signed anything to change doctors. We [MD #8 and I] had real conversations. They get me. This new guy. he came around to introduce himself. I never said I wanted to change doctors. During an interview on 7/16/26 at 7:40 AM, Resident #14 stated, I am extremely pissed off about it. They (the facility) were supposed to give us a list of doctors with a writeup about them. We never got it. By the 9th of July, we were all thinking we would get a letter about the doctor choices. On the 9th of July, I found out my doctor had been changed on my paperwork to [MD #23]. I had blood work on 7/7 and no one has followed up with me about it. I had the nurses print out a copy of the labs. There are a lot of abnormalities on it. But no one has gone over it with me. I would rather stay with [MD #7] because he/she knows me. Had I been given the opportunity to get to know about the new doctor, things may have been different. [MD #23] has yet to see me. During an interview on 7/16/26 at 7:55 AM, Resident #21 stated, I didn't like it. I have been (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	here 3 years. I can't keep switching doctors. I would prefer to stay with [MD #7]. My situation is a bit different from most. I am from Arizona; I came here to see the specialists at [Baltimore hospital]. I have a disease caused by Valley Fever. Most docs don't know much about it. I have no idea who my new doctor is. It has been a few weeks and I have not met him. I never got a piece of paper to choose my new doctor. During an interview on 7/16/26 at 8:16 AM, Resident #2 stated, I really don't have any strong feelings because I rarely saw my doctor. I would have liked to have kept my old doctor [MD#7] for reasons of familiarity and shared knowledge. I was not given a choice. I don't know the new doctor's name and have not met him. During an interview on 7/16/26 at 8:20 AM, Resident #18 stated, I am not happy with how it was done. [MD #5] told me today is my last day. That was the first that I heard about it. I did not get a flyer about the new doctor. I have not seen, heard or met the new doctor. I haven't been seen by the new doctor, don't know nothing about him. During an interview on 7/16/26 at 8:55 AM, Resident #15 stated, I was shocked and surprised. No one explained to me why this is happening. [MD #7] has kept me alive for the past three years. I was on hospice service and he/she got me well enough to get off hospice. There was a general letter about the physicians changing. I did not get a personal letter. I did not realize that it would affect me and my doctor. I did not get a letter to choose a new doctor. I was just given a new doctor, [MD#23]. He/ she came to see me this week. He/she seemed nice. I felt like I was betraying [MD #7] when I was talking to him/her (MD #23). It has upset me. But I was not given a choice to pick him/her. He/she said that my old physician was not managing me correctly. I explained that my ammonia level are always that high. He/she said he/she is now here and he/she is going to get me fixed up. During an interview on 7/16/26 at 9:10 AM, Resident #24 stated, I just think we had a relationship with our doctors. I did not get a chance to say who I wanted as a doctor. During an interview on 7/16/26 at 9:45 AM, Resident #16's representative stated, Absolutely, I was not given any notice. I have medical and financial power of attorney. My grandmother passed away 2 years ago. The facility should have a copy of the transfer of the decision-making. I do not even know who is seeing my mom now as a physician. During an interview on 7/16/26 at 10:05 AM, Resident #17 stated, I have no idea how that process (changing the doctors) worked. My NP and [MD #7] were really nice. I did not get a letter saying the docs were changing. I don't know who my new doctor is. I have not seen any doctor recently. I would like to see a doctor. I am in need my hydrocortisone ointment reordered. They gave hydrocortisone cream instead. The cream does not really work with my skin condition it dries up and flakes off and does not relieve the itch. During a telephone interview on 7/16/26 at 10:23 AM, Resident #19's representative stated, I have not received any notice about a change in physician. [Resident #19] has been there 15 years. I am currently in the court system in Maryland to get guardianship. I really did not care too much for the old doctor. But I do not know the name or contact for the new doctor. I was not even aware that the doctor had been changed. During an interview on 7/16/26 at 1:13 PM, the NHA stated, . I already told you that I did not give the residents a choice for their physician at this time. There is only one physician coming into the facility currently. Once he assesses everyone, he will recommend to the residents the other physicians on this team that he thinks will be a good fit for them. Then the facility will give the residents a sheet with a list of the physicians available for them to choose from.		

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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 record review and interview, it was determined the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, as evidenced by failing to arrange or schedule physician-ordered specialist consults, procedures, diagnostic tests, or labs. This was evident for 4 (Resident #2, #4, #3, and #26) of 4 residents reviewed for consults, diagnostic tests, and labs during the complaint survey. The findings include: On 07/15/2026 at approximately 8:05 AM, in review of Intake # 3069061, there were noted concerns related to critical physical health concerns, denied oncology tests, and insurance-related procedure refusal. On 07/15/2026 at approximately 2:00 PM, in review of intake #3074558, a noted concern related to a fall with a fracture was raised. 1) On 07/15/2026 at 9:47 AM, during an interview, Resident #2 expressed concerns regarding follow-up appointments, the procedure of a nephrostomy tube change, and follow-up appointments and tests that needed to be completed. On 07/15/2026 at 8:59 AM, during a review of Resident #2's medical record, a 05/06/2026 hospital discharge summary was revealed, directing an oncology follow-up within 2 weeks and a brain magnetic resonance imaging (MRI) without contrast. Corresponding physician orders included a brain MRI (05/06/2026), an oncology consult for melanoma (05/07/2026), and a vascular consult for right superficial femoral artery (SFA) occlusion (05/28/2026). However, there was no evidence that the oncology follow-up, brain MRI, or vascular consultation was scheduled or completed. On 07/15/2026 at approximately 9:05 AM, continued review of Resident #2's medical records revealed a 06/11/2026 physician order for an Interventional Radiology (IR) consult for nephrostomy tube replacement. On 07/15/2026 at 11:20 AM, further review of Resident #2's medical record revealed a 07/02/2026 progress note indicating the resident attended an IR appointment for tube replacement due to stitch dislodgement, but it was not replaced due to insurance issues. Although the progress note indicated the unit clerk was notified to reschedule, there was no evidence the procedure was rescheduled. On 07/15/2026 at 10:51 AM, Staff #11 (Unit Manager Registered Nurse) stated that required consults and testing are identified from the hospital discharge summary, scheduled by the unit clerk, documented under health status notes, and uploaded to miscellaneous documents. She verified that Resident #2 had no consults, tests, or nephrostomy tube change procedures scheduled, followed up on, or completed. 2) On 07/16/2026 at 8:30 AM, a review of Resident #4 revealed a progress note dated 06/20/2026 at 9:38 AM indicated a new physician order to repeat an electrocardiogram (EKG). Further review of Resident #4's medical record revealed a corresponding physician order dated 06/20/2026 at 8:09 AM to repeat EKG related to abnormal findings. However, there was no evidence in Resident #4's medical record to confirm that the EKG was completed. On 07/16/2026 at approximately 8:35 AM, a review of Resident #4's medical record revealed a 06/25/2026 physician note documenting three diarrhea episodes, one formed stool, Imodium initiation, and a pending C. diff test. However, the test-a laboratory analysis of a stool sample used to diagnose Clostridioides difficile infection, which causes watery diarrhea and severe inflammation of the colon-was not actually ordered until 06/28/2026 at 10:46 PM and returned positive on 06/29/2026, four days after the note indicated it was awaiting results. On 07/16/2026 at 11:05 AM, during an interview, Staff #13, a Licensed Practical Nurse (LPN), stated the process for obtaining an EKG requires a physician order, entry into the electronic medical record, and contacting the diagnostic testing company. If a physician orders a C.diff test via progress note, they typically notify the nurse to enter the order. Staff #13 confirmed that the 06/20/2026 EKG order was not completed and the C. diff test was delayed until four days after the physician ordered it. 3) On (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/16/2026 at 3:08 PM, a review of Resident #3's census report revealed he/she was out to the hospital on [DATE] and returned to the facility on [DATE]. On 07/16/2026 at 3:25 PM, a review of Resident #3's hospital discharge summary noted instructions for outpatient cardiology with a repeat echocardiogram in 2-3 months to monitor left ventricular heart function, otolaryngology follow-up within 2-7 days, and orthopedic surgery follow-up in 2-4 weeks for a chronic left proximal humerus fracture, including therapy and left arm non-weightbearing restrictions. However, Resident #3's medical record contained no evidence of these scheduled appointments, tests, or the non-weightbearing status. On 07/16/2026 at 3:35 PM, during an interview, Staff #20 (Unit Manager, Registered Nurse) stated that Unit Managers review hospital discharge summaries to have the unit clerk schedule appointments or tests, which are then documented in physician orders along with any weight-bearing status changes. She verified that no follow-up was completed related to the appointments or tests scheduled for Resident #3, and his/her weight-bearing status was not updated in the medical record. 4) On 07/16/2026 at 4:09 PM, a review of Resident #26's medical record revealed physician orders from 5/25/2026 for an urgent breast center referral (breast mass) and a vascular surgery consult (peripheral vascular disease) and from 5/15/2026 for a vascular consult. However, there was no evidence of scheduling or completion found in the record in relation to the referral or consults. On 07/16/2026 at 4:11 PM, during an interview, the Director of Nursing (DON) stated her expectation that all consults, tests, procedures, or referrals must be completed in accordance with physician orders and recommendations, adding that staff are required to notify her of any difficulties encountered. At this time the concern was shared with the DON.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on a review of facility documents and interviews, it was determined the facility failed to maintain an effective grievance system. This was evident for 3 of 3 months of grievance forms from the months of May through July of 2026 reviewed during the complaint survey. The findings include: On 07/16/2026 at 3:50 PM, a review of the facility's grievance forms from the last 3 months (May through July of 2026), provided to the surveyor by the Administrator revealed the following: Review of the grievance forms for the month of May of 2026 noted a concern regarding frequently delayed (until 10:00 AM) or undelivered breakfast meals. Review of the grievance forms for the month of June 2026 noted multiple areas of concern regarding care issues surrounding a hospital transfer and a subsequent refusal to return to the facility, staff members not introducing themselves, absence of paper towels in restrooms, cold food service, medication administration errors, requests for female-only care providers, delayed responses to call bells, extended wait times for pain medication, failure to provide suctioning on a regular basis, missing clothing, staff shortages due to overlapping break times, cleanliness of the shower room, inadequate ventilation, and oxygen supply being turned off for prolonged periods. Review of the grievance forms for the month of July of 2026 noted concerns regarding soiled bed linens and improper care of a central line. However, for the 3 months of May, June, and July of 2026, documentation lacked investigative actions, conclusion summaries, resolution dates, corrective measures, and evidence of how dispositions were communicated to the complainants. On 07/16/2026 at 4:25 PM, during an interview, the Administrator (the grievance officer) stated he lacks access to the online grievance portal. He acknowledged the facility had not addressed grievance forms, and the concern was shared with the Administrator at this time.		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on interview, and record review, it was determined the facility failed to ensure that residents were provided with necessary medical supplies timely. This was evident for 3 (Resident #2, #8, and #9) of 3 residents reviewed for colostomy care during the complaint survey. The findings include: 1) On 07/15/2026 at approximately 11:35 AM, a review of Intake #3053477 was conducted regarding a concern that the facility failed to provide colostomy bags, requiring the resident to use their own bags from home. On 07/15/2026 at approximately 2:00 PM, a review of Resident #2's physician orders revealed two orders dated 06/02/2026: one for an afternoon colostomy appliance change every 3 days, and another to change the colostomy bag as needed. On 07/15/2026 at 1:03 PM, during an interview, Resident #2 reported experiencing difficulties obtaining colostomy supplies. Resident #2 stated that a couple of weeks prior, staff had to scout for supplies, and on a previous occasion, there had been a multi-day wait. Additionally, Resident #2 reported that staff once placed a towel over the colostomy site due to a lack of available supplies on hand. 2) On 07/15/2026 at 1:24 PM, a review of Resident #8's medical record revealed a physician order dated 7/9/2026 for a colostomy appliance change every day shift every 3 days. On 07/15/2026 at 12:53 PM, during an interview, Resident #8 reported using personal supplies brought from home for about a week. A girl stated she would order them, but no updates have been received since. 3) On 07/15/2026 at 1:26 PM, a review of Resident #9's medical record revealed a physician order dated 7/9/2026 for a colostomy appliance change every 3 days. On 07/15/2026 at 12:57 PM, during an interview, Resident #9, who has been at the facility for a week, stated they brought 2 or 3 appliances from home but only have 1 left. He/She submitted a written request for a supply order last week but has received no updates since. On 07/15/2026 at 1:08 PM, during an interview, Staff #13, a Licensed Practical Nurse (LPN), stated that colostomy supplies are resident-specific and ordered through central supplies when low. The facility must provide all necessary supplies, and residents should not use their own supplies. On 07/15/2026 at 12:38 AM, Staff #12 (Central Supply Clerk, formerly in admissions) stated that colostomy/urostomy supplies are only ordered on a monthly basis through Gentell, a supply company. Staff #12 further noted that for residents arriving from the hospital, a 1-2 day supply is provided by the hospital because it takes 1-2 days for the facility's orders to be delivered. On 07/15/2026 at 2:28 PM, during a second interview, Staff #12 (Central Supply Clerk) clarified the process for ordering colostomy supplies for hospital admissions: admissions identify the specific type and notify Central Supply for next-day delivery. She provided an email from 07/15/2026 at 2:13 PM confirming supplies were just ordered for Residents #2, #8, and #9. The concern was shared at this time.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaint IQIES #3067494, record review and interviews, it was determined that the facility failed to accurately assess the facility's nursing staff needs and nursing staff competency needs during the annual and/or update of the Facility Assessment. This deficient practice has the potential to affect all residents in the facility. The findings include: A facility assessment is conducted annually to determine what resources are necessary to care for the residents competently during daily operations and emergencies. The assessment must include staff competencies necessary to provide the level and types of care needed for its resident population. Resident #4 was admitted to the facility on [DATE] with a nephrostomy tube (a thin, flexible tube inserted in through the patient's back directly into the kidney to drain urine) in place. A review of the Facility's Assessment report was conducted on 7/16/26 at 9:15 AM. That Facility Assessment was documented as being updated and reviewed by QAPI (Quality Assurance and Performance Improvement) committee on 11/27/25. In Part 2. Services and Care/Offered Based on Resident Needs, the assessment did not address the need for nursing staff training regarding nephrostomy tube care, in particular for training regarding the aseptic procedure of flushing a nephrostomy tube. During an interview on 7/16/26 11:00 AM, the Director of Nursing confirmed that the Facility assessment made no mention of nephrostomy tubes or the care of this device in Part 2. Services and Care/Offered Based on Resident Needs. The facility assessment did not accurately and completely address the nursing staff's educational and competency needs with regard to caring for residents with Nephrostomy tubes.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to implement and maintain an effective training program regarding nephrostomy tube care. This was evident during staff interviews while reviewing complaint #3067494 regarding nephrostomy tube flushing. The findings include: The National Library of Medicine documented that the standard of care for the procedure of flushing a nephrostomy tube requires a specific physician order to flush the tube to prevent clogging and requires strict aseptic (sterile) technique by the staff performing the procedure. The procedure requires the nurse to wash his/her hands thoroughly, disinfect the port with an alcohol swab and gently instill 5 to 10 mls (milliliters) of sterile normal saline. (2026) Review of the complaint #3067494 for Resident #4 revealed the presence of a nephrostomy tube (a thin, flexible tube inserted in a patient's back directly into the kidney to drain urine). Resident #4 was hospitalized from [DATE] to 6/17/26 with fever and vomiting and was with acute pyelonephritis (a medical term for a kidney infection). E#21 (hospital consultant Infectious Disease) documented on Resident #4's hospital consult acute pyelonephritis related to nephrostomy tube. No other symptoms to suggest an alternative cause. During an interview regarding the procedure for flushing a nephrostomy tube on 7/15/26 at 10:54 AM, Registered Nurse (RN #16) stated, We just unscrew the tube, clean it with alcohol and flush with 10 mls of normal saline solution (NSS). We use standard precautions. I don't use sterile gloves, just regular gloves. In an effort to observe a nephrostomy tube flush, an interview with Licensed Practical Nurse (LPN) #13 occurred. On 7/15/26 at 11:27 AM, LPN #13 stated, I already flushed Resident # 2's nephrostomy tube. It is a sterile procedure. You have to use sterile gloves and wash the tube off with alcohol. Then you use a sterile syringe flush with 10 ml of NSS and watch it drain back out into the nephrostomy bag. I was trained by the [staff development nurse]. She showed me how to do it. I am not sure if there was a competency check off. I have been here awhile so it was a few years ago that I was trained to do it. During an interview on 7/15/26 at 11: 40 AM, the Director of Nursing (DON) stated that the Staff developmental nurse no longer works there and she was covering that role. The DON stated that she would look for nephrostomy flushing procedure checkoffs for the nursing staff. During an interview on 7/16/26 at 11:15 AM, the Nursing Home Administrator (NHA) confirmed that the facility did not have any Nephrostomy flushing procedure competency check offs for the nursing staff. He also confirmed that the role of staff development was vacant and currently the DON was covering that role along with the Infection Preventionist role too. The facility failed to provide evidence of an effective training program regarding nephrostomy tube care and flushing procedure.		