STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215270	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solomons Nursing and Rehab Center	13325 Dowell Road Solomons, MD 20688

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 44440 Based on record review, and interview it was determined that the facility failed to notify the Resident's health care Responsible Party (RP) of a change to the Resident's plan of care. This was found evident in 1 (Resident #290) of 4 Residents reviewed for care planning. The findings include: On 8/14/24 at 9:52 AM, the surveyor reviewed Resident #290's medical record. The review revealed that Resident #290 was admitted to the facility in mid 2013. Further review revealed admitting paperwork dated 6/24/23 for Resident #290 that has a spouse/friend listed first and next a Responsible Party (RP) with a comment (representative payee). Additionally in the paper record, there was a typed note from the spouse/friend RP that stated, this RP makes medical decision for Resident #290 and to please see Maryland Health Care Decision Act paper signed on 12/15/04. On further review the surveyor noted that the designated financial RP (representative payee) was in attendance at the care plan meeting dated 2/21/19 and 2/27/20. On review of all the other care plan meeting held for Resident #290 the medical Responsibility Party was in attendance. The surveyor reviewed a progress note dated 1/14/21 that described that the Financial RP for Resident #290 was contacted regarding the end date for Medicare covered services. No mention that the medical RP was notified as well. On 8/16/24 at 9:04 AM, the surveyor interviewed the Director of Nursing (DON). In the interview the DON stated that when Medicare covered services are stopped and not covered we would contact both the medical RP and financial RP because there is a medical and financial component. On 8/15/24 at 9:16 AM, the surveyor interviewed Social Worker #17. During the interview SW #17 stated when the facility is going over a decision that a Resident would need to make the facility first determines if the Resident themselves have the capacity to make the decision. If they are deemed incapable then the facility would determine who the RP is. The surveyor asked SW#17 who is contacted when a Resident has a different medical RP than financial RP. SW#17 stated the medical RP is notified and the financial RP is only notified in regards to financial concerns. She further stated that the paperwork for these designations should be in the residents medical record. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/16/24 at 9:26 AM, the surveyor conducted a follow up interview with the DON. In the interview the surveyor relayed the concern that Resident #290's medical RP was not contacted or updated on the plan of care on three occasions because the facility notified or involved the financial RP.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 44440 Based on record review, and interview it was determined that the facility failed to inform a Resident's Responsible Party (RP) in advance of a change in the residents' plan of care. This was found evident in 1 (Resident #285) of 10 residents reviewed for Resident Rights. The findings include: On 8/27/24 at 1 PM, the surveyor reviewed Resident #285's medical record. The review revealed that Resident #285 had a past medical history that included, but not limited to, muscle weakness, malnutrition, dementia and dysphagia (difficulty swallowing). On further review of the record on a progress note dated 9/21/23 written at 7:17 PM by Licensed Practical Nurse (LPN) #18 described an incident where LPN #18 found Resident #285 on the floor. No injuries were noted after assessment and Resident #285's Responsible Party (RP) was notified. The surveyor next reviewed Resident #285's orders. An order was placed on 9/21/23 for Resident #285 to be changed from mechanical soft diet to pureed texture and chopped meats. No where in the medical record was a reason given for the diet change or that the RP was notified prior to the change in plan of care. On 8/28/24 at 9:14 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor asked the DON if a Resident's RP should be notified for diet order changes and prior to the change, for a Resident. The DON stated that any change in the plan of care a RP should be notified. The surveyor asked if there was documentation that the RP was made aware about the diet change and if the rationale for the change was in the medical record. The DON stated she would follow up. On 8/28/24 at 9:31 AM, the surveyor conducted a follow-up interview with the DON. The DON stated that LPN #18 believed the diet change was due a dental need and would have the LPN #18 explain the reason. On 8/28/24 at 9:38 AM, the surveyor interviewed LPN #18. During the interview LPN #18 was asked why Resident #285's diet was changed on 9/21/23 and if the RP was notified. LPN #18 stated she believed the diet order change due Resident #285's dentures. LPN #18 stated the Resident refused to use denture cream and didn't want to get a new pair of dentures. The surveyor followed up by asking if the RP was notified of the concern and change in plan of care prior to the diet order being changed. LPN #18 stated when a diet is changed usually speech is involved and the RP would be aware. LPN #18 stated she couldn't remember the specifics with the diet change. At the time of exit no documentation was provided to the surveyor to support rationale for diet change or that the RP was notified.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49148 Based on observation, interview with staff, and record review it was determined that the facility failed to: 1) ensure a resident has a call bell within reach and is able to use it if desired and, 2) provide reasonable accommodations for a resident to assist with mobility. This was evident for 1 (Resident #44) observed during a tour of the facility and 1 (Resident #300) out of 2 residents reviewed for accommodations. The findings include: 1) On 8/8/2024 at 8:14 AM, the Surveyor observed Resident #44 laying in their bed and the call bell on the floor at the foot of the bed. The Surveyor expressed this concern with Licensed Practical Nurse (LPN) #16, who stated she would take care of it. On 8/9/2024 at 8:00 AM, the Surveyor observed Resident #44 laying in their bed. The Surveyor asked Resident #44 where his/her call bell was in case he/she needed to call for assistance. The resident stated he/she did not know. The Surveyor observed the call bell on the floor at the foot of the bed. On 8/9/2024 at 8:10 AM, the Surveyor informed LPN #16 of the second observation. The Surveyor observed LPN#16 clean the call bell and place the call bell on the bed next to the resident. LPN #16 confirmed that Resident #44 should have a call bell within reach. 44440 2) On 8/27/24 at 1 PM, the surveyor reviewed Resident #300's medical record. The review revealed that Resident #295 had a past medical history which included, but not limited to, surgical amputation, muscle weakness, unsteadiness on feet, and need for assistance with personal care. On further review a care plan was initiated for Resident #300 on 3/16/24 stating; Resident is a potential/actual rehabilitation candidate related to recent amputation. One of the interventions listed was to refer Resident to Physical Therapy (PT), Occupational Therapy (OT) and Speech to improve resident mobility, transfer, strengthening as recommended post evaluation. The surveyor review of Occupational Therapy (OT) notes from a session dated 3/16/24 in which the OT documented, patient completed rolling to both sides with maximum assistance of 2, no bed rail available, requiring total dependence to maintain side lying to decrease caregiver burden during Activities of Daily Living (ADL)s. On a note written on 3/21/24 the OT wrote, the daughter voiced concerns that the patient does not have bedrails to assist during bed mobility, ADLs and pressure relief. The note further stated that the OT notified the team and daughters that an order for maintenance for bilateral bedrails had been placed on 3/16/24. The OT's follows by writing that the maintenance team stated they did not have bedrails available and had ordered them with a pending order. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 11:22 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the surveyor asked if a resident needed bedrails would they be available. The NHA stated the facility had recently ordered more. He recalled that all the rails were in use when Resident #300 needed them and that 10 more rails were ordered. He stated he would look for the invoice. Following the interview at 11:28 AM, the surveyor received an invoice for 10 bedrails dated 4/3/24. The surveyor voiced the concern to the NHA that the need for the bedrails was identified on 3/16/24 and the order was not placed until 4/3/24.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 42828 Based on interviews and family council meeting minutes, it was determined that the facility failed to demonstrate their prompt response and rationale on concerns from the family council group. This was evident for 5 of the 7 months of family council meeting minute notes reviewed. The findings include: The surveyor reviewed a complaint received at the Office of Health Care Quality (OHCQ) on 10/27/2023. The complaint stated that the Nursing Home Administrator did not respond to the family council group's (FCG) concerns for the months of July, August, and September of 2023. During an interview on 08/21/24 at 10:05 AM with the Nursing Home Administrator (NHA) the surveyor asked what the process in place regarding family council meetings is. The NHA stated the family council group meets monthly and then sends the meeting minute notes to him monthly by email. The NHA also stated that he responds to monthly meeting minutes every month before the next meeting occurs. The surveyor requested a copy of all monthly meeting minutes from April 2023 to October 2023. In an interview with the complainant on 8/14/2024 at 10:12 AM, it was revealed that meeting minutes were emailed to the NHA shortly at the end of the meeting. The complainant provided documented evidence of an email thread (time-stamped messages) that the meeting minute notes were sent to the NHA monthly. The surveyor reviewed the meeting minutes which revealed that the NHA did not respond promptly to the FCG's concerns for the months of April 2023, May 2023, July 2023, August 2023, September 2023. The NHA's response to April 2023 and May 2023's concerns were documented in the June 2023 meeting minutes. Further review of the meeting minutes also revealed that the response to concerns for July 2023, August 2023 and September 2023 were documented on the October 2023 meeting minute notes. The NHA and the DON were made aware of the findings throughout the survey and at exit conference.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42828 Based on record review, and interviews it was determined that the facility failed to make an effort to resolve residents' grievances. This was found to be true for 2 of 2 grievances for Resident #58, 1 of 1 grievance for Resident #18, and 6 out of 8 grievances for Resident #291. The findings include: 1a) Review of Resident #58's medical record revealed he/she was admitted to the facility on [DATE] with diagnoses including a cerebral infarction, hemiplegia and hemiparesis affecting the left non-dominant side, conversion disorder with seizures or convulsions, heart failure, chronic obstructive kidney disease, and stage 3 chronic kidney disease. Additional review of Resident #58's medical record showed a care plan created on 1/11/23 that stated Resident #58 has activities of daily living (ADL) limitations/deficits requiring staff assistance of 1 person for toilet use and transfers between surfaces. On 8/19/23 12: 45 PM Surveyors reviewed the grievance logs from 2023 through 2024. During review of the 2023 grievance binder, the surveyor noted a grievance dated 5/18/2023 written by the Director of Social Work, (SW) #17, that stated: on 5/18/23 around noon, I was walking past the Patuxent nurse's station when I heard loud yelling. I looked over and saw GNA/CMA #19 beside the med cart and Resident #58 sitting in his/her wheelchair. GNA/CMA #19 was yelling at Resident #58 about something. I can't recall what she was saying because I was so shocked to hear her yelling so loud. Further review of grievances revealed another grievance dated 4/27/23, involving Resident #58. The person voicing the concern was Resident #58 which stated he felt that staff were always rushing when providing care for him/her. The resident said that when staff wake him up in the morning, they do it by hollering at him. 1b) Review into the grievance binder labelled 2024 revealed a grievance dated 4/10/24 and the person voicing the concern was Resident #18. The grievance stated: that during a care plan meeting on 4/9/24, the reason Resident #18 wanted to move to a different unit was to get away from GNA/CMA #19 because of GNA/CMA #19 was being rough with him/her, telling him/her what to do, like a child. The grievance goes on to note that there was an incident where GNA/CMA yelled down the hall to Resident #18 you're not going to eat that candy before mealtime there were other people around and Resident #18 felt embarrassed. Review of Resident #18's medical record revealed that he/she was admitted to the facility on [DATE] with diagnoses including hemiplegia affecting the right dominant side, dementia without behavioral /psychotic/mood disturbance, cerebrovascular disease and dysphagia. Resident #18's care plan showed that due to past cerebrovascular accidents, the resident has an ADL self-care deficit with right side weakness. The resident required one staff assistance to turn and reposition in bed and with toilet use. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyors held an interview with SW #17 on 8/22/24 at 11:15 AM. Surveyors reviewed the grievances dated 5/18/23 and 4/27/23 with SW #17. SW #17 confirmed that she witnessed and documented the incident of verbal abuse when GNA/CMA #19 yelled at Resident #58 on 5/18/23 and she documented Resident #58's concerns on 4/27/23 about staff hollering at him/her. When surveyors asked SW #17 to describe the facility's grievance filing process, she stated that she is the grievance officer and the process is to type the concerns, log them, then send the grievance document to the DON, the Nursing Home Administrator (NHA), then she assigns the grievance to appropriate department supervisor for review and action. When surveyors asked SW #17 what happens after the grievances have been assigned, she stated that she is not given any results or resolutions nor responsible for following up with the grievances. SW #17 went on to say that the grievances dated 5/18/23 and 4/27/23, was given to the Unit Manager (UM) at the time, Assistant Director of Nursing (ADON), Staff #3, with a copy to the prior DON, Staff #34, and the NHA. Review of the grievances dated 5/18/23 and 4/2723 showed that the DON/UM was denoted as the assigned department supervisors to address the grievance. Later during the interview, SW #17 confirmed that the witnessed verbal abuse (Resident #58) on 5/18/23, Resident #58's grievance on 4/27/23 about staff hollering at him/her, and the grievance by Resident #18 reporting rough treatment and embarrassment, were reportable incidents but could not recall if the incidents were reported to the state. An interview was held on 8/23/2024 at 9:20 AM with the NHA. The surveyors and the NHA reviewed the two grievances related to Resident #58 and the grievance from Resident #18. The surveyor asked the NHA what the process was for any grievance filed at the facility and he replied: SW #17 is the designated grievance officer, and she documents the grievances, determines which department addresses them, and forwards a copy of the grievance to myself, the DON and the appropriate department supervisor/head of which the concern/grievance addressed. The NHA went on to say that the assigned department supervisor is to follow up with the resident/complainant in concern to resolve the grievance. The surveyor asked the NHA whether the written statement by SW #17 on 5/18/23 meets the definition of abuse, and he replied, yes. The surveyor asked the NHA about the grievance filed by Resident #58 on 4/27/23 and whether the details would be considered an allegation of abuse to which he replied: yes, it is. In addition, the surveyor asked the NHA whether the grievance filed by Resident #18 on 4/10/24 would be considered as an allegation of abuse, to which he answered, I can see how it can be interpreted as abuse. The NHA went on to say that he could see there was a pattern showing that GNA/CMA #19 was mentioned in these grievances. The surveyor requested documentation to show that the grievances were addressed. The NHA confirmed that there was no documentation of resolution or follow-up for the reviewed grievances. 44440 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 8/22/24 at 9 AM, the surveyor reviewed Resident #291's grievances filed in the facility's grievance log. On 3/9/23 Social Worker #17 documented that Resident #291's family member complained about Resident #291's phone not working, therapy questions, and food concerns. The section for follow-up stated, Social Worker would refer the summary to the Director of Nursing, Unit Manager, Dietary and Maintenance. It further described that SW #17 spoke to maintenance and a new phone would be placed in Resident #291's room and that an email was sent to the rehabilitation department explaining the family members' concerns. However, no follow up from dietary was documented. Next the surveyor reviewed a grievance statement from 4/12/23. In the statement Resident #291 stated he/she was handled roughly while being helped to reposition in a wheelchair during this interaction with a Geriatric Nursing Assistant (GNA). Resident #291 reported hitting his/her elbow on the wheelchair causing it to bleed. He/she further described the GNA as rude and wishes not to have the GNA take care of him/her again. He/she reported being left soaked in diapers for an extended period of time. Finally he/she discussed the desire to sign a waiver so he/she could drink thin liquids. No follow up was documented in regards to these three grievances. On 8/26/24 at 11:28 AM, the surveyor reviewed intake #MD00192593 sent to the Office of Health Care Quality (OHCQ). The intake described Resident #291 had made a request to switch from the A bed to B bed for accessibility reasons. It further stated the request was made several times and never was addressed. The intake also stated that clothes were missing and never returned or compensated for. On 8/28/24 at 10:36 AM, the surveyor interviewed the NHA. During the interview the NHA stated he remembered Resident #291's family member requested to switch beds to the window side but could not recall the rationale for why it did not happen. He further stated that the family reported missing clothes and were instructed to bring in receipts for reimbursement. He stated no receipts were ever brought in. The surveyor expressed the concern that those grievances were not recorded and that there was no way to see that follow through was done when the facility knew of the concerns. The NHA stated that education on the grievance procedure is currently happening with the facility staff.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on medical record review, resident interview and staff interview it was determined that facility staff failed to: 1) ensure that residents' allegations of theft were reported to in a timely manner and 2) respond to and report allegations of abuse. This was evident for 5 (Resident #68, Resident #42 and Resident #291, Resident #58, and Resident #18) of 10 residents reviewed for timely reporting and abuse. The findings: 1a) On 08/19/24 at 10:27 AM the surveyor reviewed a facility reported incident (FRI), #MD00206250, sent to the Office of Health Care Quality (OHCQ) on 6/3/24 which stated that Resident #68 reported $100 was taken from his/her wallet. The surveyor observed that the report was submitted on 6/3/24 and the date of the incident documented as 6/26/24. The discrepancy was pointed out to the Director of Nursing (DON) who confirmed it was an error and that the incident was reported to the facility by the resident on 5/25/24 and not 6/26/24. Additional review of the FRI investigation revealed a statement written by Staff #27 confirming that on 5/25/24, Resident #68 reported to her that $100 was taken from her/his purse. The facility investigation also revealed that the facility submitted an initial report to OHCQ on 5/29/24. The facility was required to submit a report to OHCQ within 24 hours of the allegation. On 08/21/24 at 08:05 AM the surveyor notified the Director of Nursing (DON) of the findings. The DON provided no additional information. 1b) On 08/16/24 at 10:00AM the surveyor review of the FRI # MD00206646 revealed a written statement on 6/2/24 from Staff#15 which stated Resident #42 reported to her that $30-$50 was stolen from his/her wallet. Further review of the FRI revealed that the facility submitted the initial report to OHCQ on 6/7/24. The facility was required to report the incident within 24 hours of the allegation. On 08/21/24 at 08:05 AM the surveyor notified the Director of Nursing (DON) of the findings. The DON confirmed no additional information. 44440 2) On 8/21/24 at 10:18 AM, the surveyor interviewed the Nursing Home Administrator (NHA) and asked if he was aware of any allegations that Resident #291 made in regards to abuse. The NHA stated he could not recall any allegations. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/24 at 9 AM, the surveyor reviewed the grievance log from 2023. A typed note dated 4/12/23 at 11 AM stated that this social worker spoke with Resident #291 regarding allegations that he/she was abused and neglected by staff. The statement described that a Geriatric Nursing Assistant (GNA) roughly grabbed Resident 291's by the arms and yanked him/her up in the wheelchair causing him/her to hit his/her elbow against the wheelchair. In the statement Resident #291 gave a description of the GNA and stated the GNA was very rough and rude while providing care. Resident #291 also stated he/she does not want this GNA to take care of him/her anymore. On 8/22/24 at 11:44 AM, the surveyor interviewed Social Worker #17. During the interview SW #17 stated that she recalls taking the statement from Resident #291 and was told by the nurse that prior to the interview that Resident #291 wanted to speak with her. After speaking with Resident #291 the GNA was identified as GNA #11. SW #17 further stated the GNA #11 no longer is employed at the facility related to another incident. The surveyor asked SW#17 if other interviews were conducted or if the allegation was reported to the NHA. SW #17 stated any time a grievance or allegation is obtained a copy of the statements is sent to the Director of Nursing (DON), Unit Manager, department head related to grievance, and the NHA. She further stated she could not recall that she was asked to follow up on this allegation. On 8/23/24 at 9:46 AM, the surveyor interviewed the NHA. During the interview the NHA confirmed Resident #291's abuse allegation was never reported to the police or the Office of Health Care Quality (OHCQ) or that an investigation was conducted to follow up on the allegation. On 8/23/24 the facility reported they reported the allegation to the police and OHCQ as well as started an investigation into the allegation. 42828 3a) Review of Resident #58's medical record revealed he/she was admitted to the facility on [DATE] with diagnoses including a cerebral infarction, hemiplegia and hemiparesis affecting the left non-dominant side, conversion disorder with seizures or convulsions, heart failure, chronic obstructive kidney disease, and stage 3 chronic kidney disease. Additional review of Resident #58's medical record showed a care plan created on 1/11/23 that stated Resident #58 has activities of daily living (ADL) limitations/deficits requiring staff assistance of 1 person for toilet use and transfers between surfaces. On 8/19/23 12: 45 PM Surveyors reviewed the grievance logs from 2023 through 2024. During review of the 2023 grievance binder, the surveyor noted a grievance dated 5/18/2023 written by the Director of Social Work, (SW) #17, that stated: on 5/18/23 around noon, I was walking past the Patuxent nurse's station when I heard loud yelling. I looked over and saw GNA/CMA #19 beside the med cart and Resident #58 sitting in his/her wheelchair. GNA/CMA #19 was yelling at Resident #58 about something. I can't recall what she was saying because I was so shocked to hear her yelling so loud. Further review of grievances revealed another grievance dated 4/27/23, involving Resident #58. The person voicing the concern was Resident #58 which stated he felt that staff were always rushing when providing care for him/her. The resident said that when staff wake him up in the morning, they do it by hollering at him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13325 Dowell Road Solomons, MD 20688	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3b) Review into the grievance binder labelled 2024 revealed a grievance dated 4/10/24 and the person voicing the concern was Resident #18. The grievance stated: that during a care plan meeting on 4/9/24, the reason Resident #18 wanted to move to a different unit was to get away from GNA/CMA #19 because of GNA/CMA #19 was being rough with him/her, telling him/her what to do, like a child. The grievance goes on to note that there was an incident where GNA/CMA yelled down the hall to Resident #18 you're not going to eat that candy before mealtime there were other people around and Resident #18 felt embarrassed. Review of Resident #18's medical record revealed that he/she was admitted to the facility on [DATE] with diagnoses including hemiplegia affecting the right dominant side, dementia without behavioral /psychotic/mood disturbance, cerebrovascular disease and dysphagia. Resident #18's care plan showed that due to past cerebrovascular accidents, the resident has an ADL self-care deficit with right side weakness. The resident required one staff assistance to turn and reposition in bed and with toilet use. Surveyors held an interview with SW #17 on 8/22/24 at 11:15 AM. Surveyors reviewed the grievances dated 5/18/23 and 4/27/23 with SW #17. SW #17 confirmed that she witnessed and documented the incident of verbal abuse when GNA/CMA #19 yelled at Resident #58 on 5/18/23 and she documented Resident #58's concerns on 4/27/23 about staff hollering at him/her. When surveyors asked SW #17 to describe the facility's grievance filing process, she stated that she is the grievance officer and the process is to type the concerns, log them, then send the grievance document to the DON, the Nursing Home Administrator (NHA), then she assigns the grievance to appropriate department supervisor for review and action. When surveyors asked SW #17 what happens after the grievances have been assigned, she stated that she is not given any results or resolutions nor responsible for following up with the grievances. SW #17 went on to say that the grievances dated 5/18/23 and 4/27/23, was given to the Unit Manager at the time, Assistant Director of Nursing (ADON), Staff #3, with a copy to the prior DON, Staff #34, and the NHA. Review of the grievances dated 5/18/23 and 4/2723 showed that the DON/UM was denoted as the assigned department supervisors to address the grievance. Later during the interview, SW #17 confirmed that the witnessed verbal abuse (Resident #58) on 5/18/23, Resident #58's grievance on 4/27/23 about staff hollering at him/her, and the grievance by Resident #18 reporting rough treatment and embarrassment, were reportable incidents but could not recall if the incidents were reported to the state. An interview was held on 8/23/2024 at 9:20 AM with the NHA. The surveyors and the NHA reviewed the two grievances related to Resident #58 and the grievance from Resident #18. The surveyor asked the NHA what the process is for any grievance filed at the facility and he replied: SW #17 is the designated grievance officer, and she documents the grievances, determines which department addresses them, and forwards a copy of the grievance to myself, the DON and the appropriate department supervisor/head of which the concern/grievance addressed. The NHA went on to say that the assigned department supervisor is to follow up with the resident/complainant in concern to resolve the grievance. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor asked the NHA whether the written statement by SW #17 on 5/18/23 meets the definition of abuse, and he replied yes. The surveyor asked the NHA about the grievance filed by Resident #58 on 4/27/23 and whether the details would be considered an allegation of abuse to which he replied: yes, it is. In addition, the surveyor asked the NHA whether the grievance filed by Resident #18 on 4/10/24 would be considered an allegation of abuse, to which he answered, I can see how it can be interpreted as abuse. The NHA went on to say that he could see there was a pattern showing that GNA/CMA #19 was mentioned in these grievances. The surveyor requested documentation to show the grievances were addressed. The NHA confirmed that there was no documentation of resolution or follow-up for the reviewed grievances. On 8/23/24 at 4:15 PM the surveyors held an interview with the NHA and the DON. The surveyors discussed concern that there was a grievance showing witnessed staff to resident abuse on 5/18/23, additional grievances filed by Resident #58 on 4/27/23 and Resident #18 on 4/10/24 alleging abuse, all of which confirmed the facility failed to ensure residents were free from abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44440

Based on record review, review of the facility's investigation files, and interviews it was determined that the facility failed to complete a thorough investigation and maintain the records of their investigation. This was found evident for 6 (Resident #291, #283, #58, #18, #28 and #38) out of 10 residents investigated for abuse.

The findings include:

1a) On 8/22/24 at 9 AM, the surveyor reviewed the investigation the facility conducted into the allegation that GNA #11 hit Resident #283 on the head three times while providing care. The summary of the investigation described that an interview was conducted with Resident #291 and Resident #291's roommate, a witness. It also described a statement was taken from GNA #11, the alleged perpetrator, who denied the allegation. The reports stated that 4 other Residents that GNA #11 was assigned to were interviewed, however it did not state the results of the interviews or have copies of the interviews that were conducted. No GNA assignment documentation was in the file to help identify the other Residents potentially affected. No actual interviews or statements were found in the investigation or evidence to show the steps reported were actually completed. No evidence was in the file to suggest that GNA #11 was placed on leave pending the investigation.

Next the surveyor reviewed GNA#11's employee file. The surveyor noted a time card that noted GNA #11 was on leave while the investigation was being conducted.

On 8/23/24 at 9:46 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concerns that in the investigation file there was no evidence to support an investigation was completed. The only document in the file was a summary of an investigation. The NHA agreed the interviews and statements were missing and should be part of the record.

1b) On 8/22/24 at 9 AM, the surveyor reviewed the grievance log from 2023. A typed note dated 4/12/23 at 11 AM stated that this social worker spoke with Resident #290 regarding allegations that he/she was abused and neglected by staff. The statement described that a Geriatric Nursing Assistant (GNA) roughly grabbed Resident 2901's by the arms and yanked him/her up in the wheelchair causing him/her to hit his/her elbow against the wheelchair. In the statement Resident #291 gave a description of the GNA and stated the GNA was very rough and rude while providing cares. Resident #291 also stated he/she does not want this GNA to take care of him/her anymore.

On 8/22/24 at 11:44 AM, the surveyor interviewed Social Worker #17. During the interview SW #17 stated that she recalls taking the statement from Resident #291 and was told by the nurse that Resident #291 wanted to speak with her. After speaking with Resident #291 the GNA was identified as GNA #11. SW #17 further stated the GNA #11 no longer is employed at the facility related to another incident. The surveyor asked SW#17 if other interviews were conducted or if the allegation was reported to the NHA. SW #17 stated any time a grievance or allegation is taken a copy of the statements is sent to the Director of Nursing (DON), Unit Manager, the department head involved and the NHA. She further stated she could not recall that she was asked to follow up on this allegation. She explained that she takes statements from Residents and does not get involved when it comes to statements or employee personnel matters.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/23/24 at 9:46 AM, the surveyor interviewed the NHA. During the interview the NHA confirmed Resident #291's abuse allegation was never reported to the police or the Office of Health Care Quality (OHCQ) or an investigation conducted to follow up on the allegation. He also confirmed that GNA #11 was able to continue to work after this allegation however was not currently employed. 42828 2a) Review of Resident #58's medical record revealed he/she was admitted to the facility on [DATE] with diagnoses including a cerebral infarction, hemiplegia and hemiparesis affecting the left non-dominant side, conversion disorder with seizures or convulsions, heart failure, chronic obstructive kidney disease, and stage 3 chronic kidney disease. Additional review of Resident #58's medical record showed a care plan created on 1/11/23 that stated Resident #58 has activities of daily living (ADL) limitations/deficits requiring staff assistance of 1 person for toilet use and transfers between surfaces. On 8/19/23 12: 45 PM Surveyors reviewed the grievance logs from 2023 through 2024. During review of the 2023 grievance binder, the surveyor noted a grievance dated 5/18/2023 written by the Director of Social Work, (SW) #17, that stated: on 5/18/23 around noon, I was walking past the Patuxent nurse's station when I heard loud yelling. I looked over and saw GNA/CMA #19 beside the med cart and Resident #58 sitting in his/her wheelchair. GNA/CMA #19 was yelling at Resident #58 about something. I can't recall what she was saying because I was so shocked to hear her yelling so loud. Further review of grievances revealed another grievance dated 4/27/23, involving Resident #58. The person voicing the concern was Resident #58 which stated he felt that staff were always rushing when providing care for him/her. The resident said that when staff wake him up in the morning, they do it by hollering at him. 2b) Review into the grievance binder labelled 2024 revealed a grievance dated 4/10/24 and the person voicing the concern was Resident #18. The grievance stated: that during a care plan meeting on 4/9/24, the reason Resident #18 wanted to move to a different unit was to get away from GNA/CMA #19 because of GNA/CMA #19 was being rough with him/her, telling him/her what to do, like a child. The grievance goes on to note that there was an incident where GNA/CMA (Certified Medication Assistant) yelled down the hall to Resident #18 you're not going to eat that candy before mealtime there were other people around and Resident #18 felt embarrassed. Review of Resident #18's medical record revealed that he/she was admitted to the facility on [DATE] with diagnoses including hemiplegia affecting the right dominant side, dementia without behavioral /psychotic/mood disturbance, cerebrovascular disease and dysphagia. Resident #18's care plan showed that due to past cerebrovascular accidents, the resident has an ADL self-care deficit with right side weakness. The resident required one staff assistance to turn and reposition in bed and with toilet use. Surveyors held an interview with SW #17 on 8/22/24 at 11:15 AM. Surveyors reviewed the grievances dated 5/18/23 and 4/27/23 with SW #17. SW #17 confirmed that she witnessed and documented the incident of verbal abuse when GNA/CMA #19 yelled at Resident #58 on 5/18/23 and she documented Resident #58's concerns on 4/27/23 about staff hollering at him/her. (continued on next page)

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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 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

When surveyors asked SW #17 to describe the facility's grievance filing process, she stated that she is the grievance officer and the process is to type the concerns, log them, then send the grievance document to the DON, the Nursing Home Administrator (NHA), then she assigns the grievance to appropriate department supervisor for review and action. When surveyors asked SW #17 what happens after the grievances have been assigned, she stated that she is not given any results or resolutions nor responsible for following up with the grievances.

SW #17 went on to say that the grievances dated 5/18/23 and 4/27/23, was given to the Unit Manager (UM) at the time, Assistant Director of Nursing (ADON), Staff #3, with a copy to the prior DON, Staff #34, and the NHA. Review of the grievances dated 5/18/23 and 4/2723 showed that the DON/UM was denoted as the assigned department supervisors to address the grievance.

Later during the interview, SW #17 confirmed that the witnessed verbal abuse (Resident #58) on 5/18/23, Resident #58's grievance on 4/27/23 about staff hollering at him/her, and the grievance by Resident #18 reporting rough treatment and embarrassment, were reportable incidents but could not recall if the incidents were reported to the state.

An interview was held on 8/23/2024 at 9:20 AM with the NHA. The surveyors and the NHA reviewed the two grievances related to Resident #58 and the grievance from Resident #18. The surveyor asked the NHA what the process is for any grievance filed at the facility and he replied: SW #17 is the designated grievance officer, and she documents the grievances, determines which department addresses them, and forwards a copy of the grievance to myself, the DON and the appropriate department supervisor/head of which the concern/grievance addressed. The NHA went on to say that the assigned department supervisor is to follow up with the resident/complainant in concern to resolve the grievance.

The surveyor asked the NHA whether the written statement by SW #17 on 5/18/23 meets the definition of abuse, and he replied yes. The surveyor asked the NHA about the grievance filed by Resident #58 on 4/27/23 and whether the details would be considered an allegation of abuse to which he replied: yes, it is. In addition, the surveyor asked the NHA whether the grievance filed by Resident #18 on 4/10/24 would consider as an allegation of abuse, to which he answered, I can see how it can be interpreted as abuse. The NHA went on to say that he could see there was a pattern showing that GNA/CMA #19 was mentioned in these grievances. The surveyor requested documentation to show the grievances were addressed. The NHA confirmed that there was no documentation of resolution or follow-up for the reviewed grievances.

On 8/23/24 at 4:15 PM the surveyors held an interview with the NHA and the DON. The surveyors discussed concern that there was a grievance showing witnessed staff to resident abuse on 5/18/23, additional grievances filed by residents on 4/27/23 and 4/10/24 alleging abuse, all of which confirmed the facility failed to ensure residents were free from abuse.

49148

3a) On 8/22/2024 at 12:00PM, a review of the FRI investigation file revealed that on 12/8/2022 at approximately 1:15 PM, the Resident #28 reported that Geriatric Nursing Assistant (GNA) #11 was rough when providing cares, refused to get the resident out of bed multiple times, and did not leave the call bell in reach.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional review of the FRI investigation file revealed that the incident was reported to the Office of Health Care Quality on 12/8/2022 at 2:00 PM and the facility concluded its investigation on 12/13/2022 at 2:00 PM. The investigation file did not include documentation of a head to toe assessment, staff interviews or statements, other resident interviews or statements, an interview with the GNA perpetrator, nor education provided to the GNA perpetrator regarding abuse, resident rights, or proper transfer technique. During further review of Resident #28's electronic and paper medical record, the Surveyor discovered that there was no documentation of the abuse incident occurring on 12/8/2022. On 8/23/2024 at approximately 4:00PM, the Director of Nursing (DON) #2 informed the Surveyors that she noticed most FRI investigations had not been thoroughly investigated prior to her employment with the facility in May of 2023. 3b) On 8/22/2024 at 12:30 PM, the Surveyor reviewed GNA #11's employee file and discovered a statement made by Staff Scheduler #30 on10/6/2023 regarding a conversation she had with Resident #38. The statement revealed that GNA #11 had hit Resident #38 and was mean to the resident on 10/6/2023 during the day shift. Staff Scheduler #30 stated that she immediately reported the information to the charge nurse during her shift and unit manager that same evening. On 8/23/2024 at approximately 11:30 AM, the Surveyor asked DON #2 for the Facility Reported Incident (FRI) investigation file regarding Resident #38's allegation of abuse from the accused the perpetrator, GNA #11. The DON #2 was unable to provide the Surveyor with the FRI investigation file and stated, We just can't find it. DON #2 was able to provide documentation that a facility submitted a self-report to the Office of Health Care Quality on 10/9/2023 at 5:16 PM, but unable to provide any other documentation. There was no other documentation in Resident #38's electronic or paper medical record regarding this FRI.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review, and interview it was determined that the facility failed to: 1) conduct care plan meetings after each Resident Assessment, 2) hold quarterly care plan meetings for residents, and 3) failed to include interventions for a resident's activity care plan. This was found evident in 3 (Resident #290, #8, and #72) out of 4 residents reviewed for care planning. The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). 1) On 8/14/24 at 9:52 AM, the surveyor reviewed Resident #290's medical record. The review revealed that Resident #290 was admitted to the facility in mid 2013. Next the surveyor reviewed the MDS assessment for Resident #290 along with the care plan meeting notes and sign in sheets. Resident #290 had a quarterly MDS assessment on 8/16/20 and 11/16/20 however no care plan meeting notes were noted for these assessment dates. On 8/16/24 at 7:39 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated she was not the DON at the time of these assessments and could not find any additional documentation that the care plan meetings were done following the 8/16/20 MDS assessment and 11/16/20 assessment. On 8/16/24 at 9:08 AM, the surveyor interviewed the Social Worker #17. During the interview the SW#17 stated she started working at the facility in 2021 and when she started the process for scheduling care plan meetings was for the facility to mail a letter to the Responsible Party (RP) and have the RP call and make the care plan meeting. She followed by stating that meetings were not being done. She further stated that currently the MDS coordinator gives the list of Residents who had their MDS assessment to the front desk and they call to make the care plan meeting with the RP. 50504 2) The surveyor reviewed Resident # 8's medical record on 08/14/24 at10:38 AM. The review revealed that Resident #8 had a quarterly MDS assessment completed on 08/02/24 and an annual assessment completed 05/11/24. There was no evidence in the medical record that a care plan meeting was held with Resident# 8 or Resident#8's representative and the interdisciplinary team around the time of either the quarterly or the annual MDS assessments. A further review on 08/14/24 at 10:45 AM revealed the last careplan meeting was held on 12/5/23 at 11:30 AM and the resident's spouse and son attended. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor interviewed the Director of Social Work, SW #17, on 08/15/24 at 9:15AM. During the interview, SW #17, stated I do not have a record to show that a careplan meeting was held for Resident #8 after 12/5/23. We keep a log of residents' care plan meetings. The surveyor asked the SW #17 for a copy of the log. The log was reviewed for the period January 2024 to July 2024. Resident #8's name or his/her RP did not appear on the log. 3) A review of Resident #72's medical record on 08/19/24 at 8:10AM revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Major Depressive Disorder. A careplan was developed on 8/12/24 for therapeutic activities. The goal stated The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date. Date Initiated: 08/12/2024 Target Date: 08/20/2024. There were no interventions indicated on the care plan to achieve the goal. 08/19/24 at 08:32 AM the surveyor notified the DON of the findings and inquired as to the reason there were no interventions for therapeutic activities on Resident #72's careplan. The DON stated she did not know but would ask the Activities Director. Later on 08/19/24 at 4:30 PM, the surveyor observed that Resident #72's Careplan was updated with interventions for therapeutic activities.

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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. 44440 Based on record review, interview, and observation it was determined that the facility failed to provide necessary services to maintain good personal hygiene for dependent Residents. This was found evident in 2 (#291 & #45) out of 8 Residents reviewed for Activity of Daily Living (ADL) cares. The findings include: 1a) On 8/20/24 at 12:18 PM, the surveyor reviewed Resident # 291's medical record. The review revealed that Resident #291 was admitted in late January 2023. Further review revealed that Resident #291 had a past medical history that included, but not limited to, dysphagia (difficulty swallowing), dysphonia (disorder of the voice), muscle weakness, unsteadiness of feet and need for assistance with personal cares. On further review a progress note written by Licensed Practical Nurse (LPN) #13 stated Resident #291 requires extensive assistance with ADLs and uses a wheelchair and walker while in the facility. On 8/21/24 at 12:20 the surveyor requested shower records for Resident #291 from the Director of Nursing (DON). On 8/22/24 at 7:16 AM, the surveyor reviewed the shower and skin sheets provided by the DON. The first date on the shower sheet was dated 2/21/23 and Resident #291 had no documentation that a shower was completed on that day. On 2/24/23, 3/3/24, 3/7/23, 3/10/23, and 3/14/23 Resident #291 had a shower documented as completed. No documentation for a shower on 3/17/23 and on 3/21/23 a bed bath was documented as given due to a refusal, Again no documentation of a shower was given on 3/24/23 or 4/7/23. The surveyor interviewed the DON after review of the records. The DON stated she was unable to find the shower sheets for the earlier part Resident #291's stay. She further stated that without documentation she would not be able to confirm that showers were done. The surveyor reviewed the facility's policy and procedure for shower and tub baths. In the policy it states, at a minimum, the resident will be offered at least 2 full baths or showers per week. The policy further states that the date and time of the shower or tub bath was performed should be documented as well as if the Resident refused with the intervention taken. 1b) On 8/27/24 at 6:13 AM, the surveyor observed from the hallway that Resident #45's call light was on and noted a staff member walk into the room. Shortly after the light was turned off and that same staff member left the room to attend to an alarm from the room next door. On 8/27/24 at 6:14 AM, the surveyor knocked and entered into Resident #45's room and observed that Resident #45 was the only resident in the room, The surveyor interviewed Resident #45 and asked if he/she had just put on the call light. Resident #45 responded yes and that he/she told the Geriatric Nursing Assistant (GNA) that he/she needed to go to the bathroom. He/she further stated because of the limitations he/she had he/she would probably have to use a bedpan and was waiting for physical therapy to get up. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER: Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 13325 Dowell Road, Solomons, MD 20688	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the interview the surveyor observed, from the hallway, the GNA who answered the light return into Resident #45's room, retrieve a paper and a phone, and walk out of the room and down the hallway. On 8/27/24 at 6:39 AM, the surveyor asked staff at the nurses station for the staffing assignments and was informed that GNA #21 was assigned to Resident #45. On 8/27/24 at 6:54 AM, the surveyor interviewed GNA # 21. During the interview the surveyor asks if the night shift GNA had given report and if she was aware that Resident #45 had requested to use the restroom. Staff #21 stated she was not aware and at this time looked up and stated that Resident #45's call light just went on and that she would go talk to Resident #45. The surveyor followed GNA #21 to Resident #45's room and heard Resident #21 report he/she needed to use the bathroom. On 8/27/24 at 6:56 AM, the surveyor interviewed the Registered Nurse (RN) Staff #27 the nurse assigned to Resident #45 on the night shift. She stated it was never reported to her that Resident #45 had to use the bathroom this morning. The surveyor reviewed Resident #45's care plans. A care plan was initiated stating, Resident #45 has Activities of Daily Living (ADL) limitations requiring staff assistance for bed mobility, locomotion, walking, bathing, hygiene/dressing, oral care, toileting, transferring related to activity intolerance. Additionally, Resident #45 had a care plan stating he/she was at risk for bladder/bowel incontinence related to impaired mobility. On 8/27/24 at 7:16 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor described the observation that Resident #45's request to use the bathroom was first addressed 52 minutes after the first request and only after putting on the call light again. The DON agreed that the resident's needs should have been addressed timely and after the first request.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record facility policy review, and interviews, it was determined that the facility failed to: 1) adequately document responses to treatment of skin conditions and 2) provide 2-person assistance to ensure resident safety during transfers. This was found evident for 2 (Resident #291 an #29) of 4 residents reviewed for wounds and resident- assisted transfers. The findings include: 1) On 8/20/24 at 12:18 PM, the surveyor reviewed Resident # 291's medical record. The review revealed that Resident #291 was admitted in late January 2023. Further review revealed that Resident #291 had a past medical history that included, but not limited to, dysphagia, dysphonia, muscle weakness, unsteadiness of feet and need for assistance with personal cares. The surveyor reviewed the progress notes for Resident #291 and discovered on 2/20/23 that Licensed Practical Nurse (LPN) #16 documented that Resident #291 had an open area to the coccyx and that the area was cleaned, a foam dressing was applied and the doctor and Responsible Party (RP) was made aware. On that same day Registered Nurse RN #3 documented on assessment there was no open area noted and that the sacrum had blanchable redness. The note further stated treatment was ordered, barrier cream applied and foam dressing placed. On 2/28/23 Staff #3 wrote a note again stating that Resident #291 has blanchable redness to the sacrum and that barrier cream and a foam dressing were applied. The note further stated Resident #291 had an order for daily dressing changes. On further review of the progress notes dated 3/1/23, 3/13/23, 3/15/23, 3/18/23 and on 3/19/23 treatment to the sacral area is documented as done, however no description of the skin integrity was documented. Licensed Practical Nurse (LPN) #24 documented the area as a sacral wound. On 8/28/24 at 1:27 PM, the surveyor interviews RN #3. During the interview RN #3 stated that she remembered that Resident #291 did not have an open wound and she recalls re-assessing Resident #291 after a nurse had written it was open. The surveyor asked RN #3 where the characteristics of the wound were documented. She stated that in her notes and it was documented as blanchable redness not open. The surveyor reviewed the Treatment Administration Records (TAR) for Resident #291 for March and April of 2023. On review an order was entered on 2/20/23 and stated to cleanse open area to sacrum with normal saline, dry, apply zinc and optifoam dressing daily and as needed for wound care. Review of the March TAR showed on 3/21/23, 3/23/23 and 3/29/21 no dressing change was documented as done. On review of the April 2023 TAR on 4/7/23 and 4/11/23 no dressing change was documented as done. On 4/24/23 a new order was written that stated, Apply barrier cream to Moister Associated Damage (MAD) to sacrum every shift and as needed for wound care. These orders were checked and completed for April 2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility's policy and procedure titled, Non-Pressure Ulcers/Injury Wound Management. The policy lists arterial ulcers, diabetic ulcers, Moisture-Associated Skin Damage (MASD), surgical wounds, venous or stasis ulcers as examples and gives the definitions. In the general guidelines it states, staff will be encouraged to promptly report any observations of change in the resident ' s skin integrity. It further states evaluation/assessment of non-pressure injury wounds will be completed weekly and with significant changes in condition of the ulcer/injury by the licensed nurse and/or practitioner. The documentation of the evaluations /assessment of the wound will be maintained in the resident's medical record and interventions to promote healing of the wound and to minimize recurrence of development will be incorporated in to the resident's care plan. Resident centered interventions and treatments will be prescribed by the physician/practitioner and administration of the treatments will be documented in the resident ' s medical record. Documentation may include; Location of wound, date the wound was acquired, Description of the wound to include measurements (length, width, depth), presence/absence of any tunneling or undermining, type of tissue (epithelial, granulation, sloth necrosis, ect), presence/absence and type of drainage, surrounding tissue description, and presence/absence of pain with the wound. On 8/29/24 at 7:40 AM, the surveyor conducted an interview with the Director of Nursing (DON). In the interview the surveyor asked where the weekly assessments of the skin condition were located. The DON stated weekly skin assessments are completed and checked on the TAR and the shower sheets. The surveyor asked about documentation of identified skin conditions or wounds and documentation of characteristics or measurements. The surveyor relayed the concern that if the skin condition/wound is not documented with characteristics or measurements weekly, then how can the facility measure or know if the treatment is working or appropriate. The surveyor also showed the DON the missing date of wound care documentation for Resident #291 for both March and April of 2023. 50504 2) Review of the Facility Reported Investigation (FRI) for MD00206729 revealed that Resident #29 was admitted to the facility on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infraction affecting Right Dominant Side, Acquired Absence of Right Leg Above the Knee, Conductive hearing Loss and Chronic pain. On 08/22/24 at 12:15 PM an interview with Resident #29 revealed that he/she experienced pain in the left shoulder while being transferred by an aide. The resident could not remember the date of the incident. On 08/22/24 at 12:35PM a review of Resident's #29 medical record revealed the resident reported to Staff #24 that on that on 6/15/2024 at approximately 2030 the assigned GNA, transferred him/her in a rough manner from wheelchair to bed. The transfer caused the resident to injure the left shoulder causing him/her to yell out in pain. Resident #29 also reported the incident to Staff# 26 on 6/15/24 at 9:30 PM. On 06/17/24 an X-ray of Resident #29's left shoulder was done and the result was, There is no fracture or periosteal reaction Resident #29 Physician's Order stated, the resident requires 2-person assist for transfers. Start Date10/11/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #29's Care Plan stated the resident has limited physical mobility relating to disease process arthritis and right AKA (Above the Knee Amputee). Intervention: I need the assistance of 2 caregivers for boosting up in bed. Date initiated: 02/07/24. On 08/27/24 at 07:21AM the surveyor informed the Director of Nursing of the findings and of the potential for injury related to Resident # 29's one-person transfer instead of a two person transfer. The DON responded I understand what happened.

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F 0687

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate foot care.

44440

Based on record review, review of hospital records, and interviews, it was determined that the facility failed to provide adequate treatment for an identified foot concern that resulted in harm to the resident. This was found evident in 1 (Resident # 296) out of 1 resident reviewed for foot care.

The findings include:

On 8/14/24 at 12:22 PM, the surveyor reviewed Resident #296's medical record. The review revealed that Resident #296 was admitted to the facility in early 2017 and had a past medical history that included, but not limited to, type 2 diabetes mellitus with diabetic neuropathy (nerve damage), hyperlipidemia (too many lipids/fats in blood which can clog arteries) and dementia.

Further review of the medical record revealed on 2/24/21 a Podiatrist (a healthcare provider who specializes in treatment of the feet) treated Resident #296 and described the treatment and recommendations in a note. The note documented that the right great toe was erythematous (abnormally reddened/inflamed) at the visit. If further stated that topical antibiotic ointment was applied and asked that the staff, please continue to monitor and treat until resolved. The note also stated, further routine podiatry care is medically necessary for this patient due to history of atherosclerosis (a hardening of arteries from plaque made of lipids/fats and other substances which can decrease blood flow) and therefore increase risk of infection and to a greater extent amputation. Non-professional treatment is hazardous to the patient. The visit note had a diagram of the foot and the left greater toe was circled with a hand written note erythematous toe.

The surveyor reviewed the Treatment Administration Record (TAR) for February, March and April of 2021. No order was written for antibiotic ointment or monitoring of the erythema noted. There was no documentation in the medical record that clarified whether it was the right or left toe that was reddened/inflamed nor was there evidence that the affected toe was treated.

Review of a progress note written by a Psychiatric Nurse Practitioner (NP) that documented an assessment completed on 3/18/21 revealed Resident #296 was assessed as being restless and having an irritable mood. The NP recommended starting Depakote (a medication prescribed to treat seizure disorders and certain psychiatric conditions).

Further review of the medical record revealed a fax sent on 3/19/21 to the Resident's primary care physician Staff #22. The fax note stated that Resident #296 continued to have verbal and physical aggression, and that Resident #296 had an abrasion on his/her toe related to kicking a door.

The surveyor reviewed the Medication Administration Record (MAR) and TAR for March 2021. No order for Depakote or treatment for the abrasion of the toe was written.

The surveyor reviewed a progress note written on 4/8/21 by Licensed Practical nurse (LPN) Staff #13. The progress note stated that Resident #296 was noted to have redness to the left greater toe and that the toe was swollen and warm to touch. The note further described the toe as having a white tip with an open area between the great toe and second toe. The note concluded by stating a fax was sent to Staff #22, Resident #296's primary care provider.

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F 0687 Level of Harm - Actual harm Residents Affected - Few	The surveyor reviewed the orders, and a telephone order was placed on 4/8/21 by Registered Nurse Staff #10 for a dressing for the left greater toe. Further review of the medical record revealed a progress note written by Staff #13 the following day (4/9/21). The note stated that the fax sent on 4/8/21 to Primary Care Physician #22 was sent unsuccessfully and resent on 4/9/21. The note stated that Staff #22 replied to fax and ordered an x-ray to the foot and ordered a consult from Wound Physician #23. The note further described that the left greater toe had two open areas, and the left pinky toe had torn skin above the nail. The surveyor reviewed the consult note from the assessment on 4/9/21 by Staff #23. The note described the left greater toe as painful and swollen with two areas measuring 5 by 5 centimeters. It also stated a skin tear was noted at distal (far) 5th toe. The plan recommended an antibiotic and an x-ray. Staff #23 concluded the note by stating she would inform Staff #22. Surveyor review of the April 2021 MARs revealed no evidence that antibiotics were ordered. On 8/19/24 at 10:58 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON confirmed in 2021 the facility was utilizing Staff #23, one of the primary care physicians, as a wound consult provider, however, Staff #23 no longer worked at the facility, and wound consults were now done by an outside wound care provider. On 8/20/24 at 12:38 PM, the surveyor conducted a phone interview with Primary Care Physician #22. During the interview Staff #22 stated in 2021 he would consult Staff #23 for wound concerns. He further stated he was unaware of any additional education she received for wound care but was aware that Staff #23 had seen residents in the area for wound treatments. Staff #22 could not recall if he had received Staff #23's recommendation for treatment of Resident #296's foot wound. He further stated he could only remember that he last saw Resident #296 on 4/9/21 by his records. The surveyor reviewed a progress note written by Staff #10 on 4/13/21. The progress note described that Resident #296's left foot dressing was sticking to his/her sock. It further described that after applying wound cleanser to the dressing it loosened, and the left greater toe had an erosion of the tip and an area macerated with bone exposed in the center. Staff #10 stated she notified Staff #22 and received an order to transfer Resident #296 to the emergency room for further evaluation. On 8/19/24 at 7:52 AM, the surveyor reviewed Resident #296's hospital records. The review revealed that Resident #296 was admitted to the hospital on 4/13/24 and started on antibiotics. On 4/14/21 Resident #296 had a bone scan done and the scan results were consistent with osteomyelitis (bone infection) of the left big toe. On 4/14/21 a wound nurse documented that the left Hallux (big toe) had exposure of the tip of the distal phalanx (top section of the toe) which was dry/dehydrated and dull in appearance. There was no active drainage at the time. The surrounding outermost layer of the skin consisted of both partial thickness and full thickness (a wound into the fat tissue, muscle, bone, or tendons) injury. The presentation suggested that this injury has been present for some time. Further review Resident #296 's hospital records revealed that a partial first ray amputation (a surgical procedure that removes the big toe and part of the first metatarsus (the bone in the foot behind the big toe) was performed on 4/19/21. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	On 8/22/24 at 9AM, the surveyor conducted a follow-up interview with the DON. The surveyor asked for any documentation that the wounds identified starting in February of 2021 were evaluated by staff and for any documentation that treatment was provided for before 4/8/21 for Resident #296. At the time of exit no additional documentation was provided to the surveyor.

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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 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. 44440 Based on record review and interviews it was determined that the facility failed to provide routine administration of medications timely. This was found evident in 1 (Resident # 298) of 5 residents reviewed for medication administration. The finding include: On 8/15/24 at 1:16 PM, the surveyor reviewed Resident #298's medical record. The review revealed that Resident #298 was admitted to the facility early April of 2021 with a past medical history that included, but is not limited to, type 2 diabetes, disorientation, epilepsy (a brain disorder that causes seizures), and acute cystitis (infection/inflammation of the urinary tract system). The surveyor reviewed a progress note written on 4/17/21 by Licensed Practical Nurse (LPN) #29 that stated at 10:40 AM, upon initial assessment, Resident #298 was found nearly unresponsive and per report from the aide was not responsive enough to eat breakfast this morning. The surveyor next reviewed the Medication Administration Record (MAR) for April of 2021. The record revealed that Resident # 289 was given a scheduled 6 AM medication at 6:18 AM on 4/17/21. The next medication due to be given was Glimepiride (a medication used to treat high blood sugars in diabetics) and was scheduled for 8:30 AM. The administration record for this medication stated see progress note. The surveyor reviewed the progress note written on 4/17/21 at 12:28 AM by LPN #29. The note stated, unable to administer due to altered mental status and Resident #298 was being transferred out via Emergency Medical Service. On 8/19/24 at 1:42 PM, the surveyor reviewed the MAR with the Director of Nursing (DON). The Director of Nursing stated it is policy to give medications 1 hour before or 1 hour after the medication is due to be given. The surveyor relayed the concern that LPN #29 appeared not to have attempted to give Resident #298 his/her scheduled medication until 10:40 AM, 2 hours after the scheduled time. The DON confirmed there was a delay in medication administration.