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	01/16/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, record review, facility document review, and facility policy review, the facility failed to assess, document, and notify the physician, oncoming staff, and the responsible party of a fall for 1 (Resident #2) of 3 sampled residents reviewed for falls.Findings included: A facility policy titled, Fall Prevention Program, revised 12/2025 indicated 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. An admission Record revealed the facility admitted Resident #2 on 09/19/2025. According to the admission Record, the resident had a medical history that included heart failure, polyneuropathy disorders of the bone density, protein-calorie malnutrition, and anemia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/21/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial to maximal assistance with bed mobility, sitting, standing, transferring and toileting and had no falls since this admission. Resident #2's Care Plan Report included a focus area initiated 09/20/2025, that indicated the resident was a high risk for falls related to impaired mobility and poor safety awareness. Resident #2's Health Status Note dated 12/11/2025 at 6:00 AM, revealed Registered Nurse (RN) #20 was getting the resident out of bed and noted the resident's left foot and ankle area with a moderate amount of swelling and pain with movement, also a purplish discoloration to the resident's lower leg near the shin was present with multiple abrasions. Resident #2's Health Status Note dated 12/11/2025 at 2:30 PM, revealed Licensed Practical Nurse (LPN) #3 went into Resident #2's room after report at approximately 9:30 AM and noticed the resident's ankle did not appear to be appropriate and had purple discoloration. Per the Health Status Note, LPN #3 requested the physician look at the resident's leg because it looked dislocated from his observation. The Health Status Note indicated the physician requested the resident be sent to the hospital for evaluation. The Emergency Medical Services System form dated 12/11/2025 at 10:40 AM, revealed Resident #2 was transported to the emergency room (ER) for evaluation of a possible left ankle dislocation. Resident #2's hospital note dated 12/11/2025 at 1:13 PM, revealed an x-ray of the resident's left ankle showed a comminuted fracture that involved the distal shaft of the tibia and distal shaft of the fibula. The Facility Reported Incident Follow-Up Investigation Report Form dated 12/17/2025 at 10:02 AM, revealed during the investigation, staff interviews revealed Resident #2 had a fall from bed at approximately 6:00AM on 12/10/2025. RN #21 confirmed she was aware of the fall and did not notice any issues with the resident's ankle. Geriatric Nursing Assistant (GNA) #22 was assigned to Resident #2 on 12/10/2025 and reported to RN #21 that the resident's ankle looked wobbly on 12/10/2025. During an interview on 01/13/2026 at 2:15 PM, Certified Medication Aide (CMA) #6 stated she worked with Resident #2 on 12/10/2025 and she did assist with (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placing Resident #2 back in their floor bed, but only after she asked GNA #22 if the nurse had assessed the resident since staff had been trained not to move any resident until the nurse assessed the resident. According to CMA #6, GNA #22 stated the nurse assessed the resident. CMA #6 stated she did not observe any changes with the resident's legs and did not complain of any pain. During an interview on 01/13/2026 at 2:28 PM, GNA #22 stated on the morning of 12/10/2025 at 6:00 AM she reported to RN #21 the resident's leg was wobbly. GNA #22 stated she asked CMA #6 to assist in getting Resident #2 back to bed. Per GNA #22, CMA #6 asked her if the nurse had done the assessment and she stated yes. GNA #22 stated Resident #2 was placed back in bed and denied pain. During a telephone interview on 01/5/2026 at 3:18 PM, RN #2 stated Resident #2 fell from bed on 12/10/2025. RN #2 stated she looked at the resident and did not observe any injuries. RN #2 stated she did not follow through with the required paperwork or document the resident's fall. RN #2 stated she was not sure she reported the fall to anyone on the oncoming shift. During an interview on 01/15/2026 at 10:10 AM, the Director of Nursing (DON) stated Resident #2 had multiple falls the days prior to 12/10/2025 and all were reported until 12/10/2025, which should have been reported. The DON stated it was expected that staff would assess a fall, document the fall, report the fall to the oncoming staff, the physician, and the responsible party. According to the DON, RN #21 did not do this. During an interview on 01/16/2026 at 5:15 PM, the Administrator stated he expected changes in a resident's condition to be reported, assessed, the provider and responsible parties to be notified and all documentation to be completed.