

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews with facility staff, it was determined that the facility failed to ensure that meals were delivered to residents at safe and palatable temperatures. This was evident for 1 (Resident #6) out of 1 resident during test tray and tray service line temperature observations. This practice has the potential to affect all residents who receive meals prepared by the facility. The findings include: Hot food must be served at 135 F (57 C) or above. Cold food must be served at 41 F (5 C) or below. All foods must be stored, held, and served at these temperatures to ensure safety, prevent bacterial growth, and maintain palatability. Staff must monitor and document temperatures according to facility policy and food safety regulations. On 01/28/2026 at 11:58 AM, during a kitchen tray service line observation with facility [NAME] #17, the surveyor observed the following food and beverage temperatures: pork loin at 100 F, apple juice at 43 F, and a milkshake at 42 F. On 01/28/2026 at 12:00 PM, an interview was conducted with [NAME] #17 regarding food temperatures. She stated that the tray line temperature should be maintained between 150-160 F and that she would place the pork loin back into the hot steamer for 10 minutes. On 01/28/2026 at 12:15 PM, the Food Service Director (FSD) rechecked the pork loin, and the temperature was 50 F. On 01/28/2026 at 1:04 PM, during a lunch meal cart observation on the Chesapeake Unit with the FSD, the following temperatures were observed on Resident #6's lunch tray: Sweet and Sour Pork at 82 F, steamed broccoli at 90 F, fried rice at 80 F, diced pineapple at 50 F, and fat-free milk at 51 F. On 01/28/2026 at 1:15 PM, the surveyor conducted a lunch test tray during a meal cart observation on the Patuxent Unit, cart #3, with the FSD. The following temperatures were observed: sweet and sour pork at 100 F, fried rice at 90 F, steamed corn at 100 F, and whole milk at 45 F. On 01/28/2026 at 1:45 PM, an interview was conducted with the FSD regarding food temperatures, and she confirmed the concerns identified above.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with facility staff, it was determined that the facility failed to store food in a manner consistent with professional standards for food service safety. This was evident in 2 of the 3 kitchen observations conducted during the recertification survey. The findings include: During the initial tour of the main kitchen conducted on 01/22/2026 at 8:028 AM the Surveyor and Food Service Director (FSD) observed the following expired food items in the dry storage area: 1 bottle Imperial Ground Allspice, expired 11/10/2020; 1 bottle Imperial Fancy Spanish Paprika, expired 9/14/2024; 2 bottles Imperial Ground Allspice, expired 1/12/2022; 1 bottle Italian Seasoning, expires 9/15/2025; 1 bottle Crushed Red Pepper, expired 1/31/2024; 6 packages Lemon Pudding Mix, expired 5/10/2024; 1 box Animal Crackers, expired 8/8/2025; 1 box Oreo Cookies, expired 3/21/2025; 1 box Cheez-It Snack Crackers, expired 9/4/2025; 1 box [NAME] Shortbread Cookies, expired 8/22/2025; 1 box Nabisco [NAME] Crackers, expired 10/18/2023; 1 box Cream of Rice, expired 4/17/2025; 2 boxes 2.0 High-Calorie Nutritional Drink, chocolate natural flavor, expired 8/20/2024; 1 box Tomato Juice, expired 7/25/2025; 1 box Vanilla Instant Pudding, opened with no open date; and 1 box Chocolate Instant Pudding, opened with no open date. In addition, two (2) cans of whole kernel golden corn were observed to be dented, which may compromise the integrity and safety of the food. On 01/22/2026 at 9:15 AM, during a tour of the walk-in refrigerator with the Food Service Director (FSD), the surveyor observed sliced bologna stored in a white plastic container with a green lid that was not dated. During an initial walk-through of the main kitchen on 01/22/2026 at 9:20 AM with the Food Service Director (FSD), the surveyor observed fifteen (15) boxes of food deliveries stored directly on the floor in front of the dry storage room door. On 01/22/2026 at 9:25 AM, during an interview with the FSD, she stated that the delivery personnel had just delivered the items and staff were awaiting to put them away. The FSD further stated that food items are not supposed to be stored directly on the floor and that the sliced bologna was required to be dated. On 01/22/2026 at 9:30 AM, the surveyor informed the FSD of the above concerns, and the FSD acknowledged receipt. On 01/28/2026 at 12:20 PM, the surveyor observed the following items sitting on the floor in the dry storage area: 4 boxes of Chocolate Flavored Shake, 5 boxes of Vanilla Flavored Shake, 5 boxes of Glucerna, 2 boxes of High Protein Ensure Vanilla, and 5 boxes of Ensure Plus.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interviews and record reviews it was determined that the facility failed to maintain residents dignity. This was evident for 2 (Resident #9 and #69) out of 2 residents observed for dignity and privacy during the recertification survey. The findings include: A urinary catheter is a flexible tube inserted into the bladder to drain urine. The catheter is connected to a drainage bag, which collects the urine. A catheter privacy bag, often called a catheter bag cover or holder, is a discreet pouch designed to cover and conceal urine collection bags. It promotes dignity, reduces embarrassment in public, and securely holds drainage bags to wheelchairs, walkers, or bedside rails using straps. 1. On 01/22/2026 at 10:42 AM, an observation was made of Resident #9 in his/her room. The Resident's urinary catheter bag was hooked to the side of the wheelchair, and the catheter did not have a privacy bag. On 02/02/2026 at 9:54 AM, a record review of the facility's Catheter Care Policy showed that it requires, Privacy bags will be available and catheter drainage bags will be covered at all times while in use. On 02/02/2026 at 10:07 AM, an interview was conducted with the Administrator. The surveyor communicated that Resident #9 was observed with the urinary catheter bag exposed, without a privacy bag in place, in contradiction to the facility's policy. The Administrator acknowledged and understood the concern. 2. During an observation of Resident #69 on 1/23/2026 at 12:18 PM he/she was seen sitting in front of the nursing station in his/her wheelchair with a urinary catheter drainage bag hooked to the bottom of the wheelchair and the drainage bag was not in a privacy bag. During an interview with GNA #20 on 1/23/2026 at 12:20 PM he reported that there should be a privacy bag over the drainage bag for Resident #69. He advised the privacy bag for Resident #69 had ripped and he needed to get the Resident a new bag. During an additional observation Resident #69 on 1/23/2026 at 12:35 PM he/she now had the drainage bag inside of a privacy bag while sitting at the nursing station. During a review of the facility Catheter Care Policy on 1/28/2026 at 1:47 PM it reported that Privacy bags will be available and catheter drainage bags will be covered at all times while in use and Privacy bags will be changed out when soiled, with a catheter change or as needed. During a review of medical records for Resident #69 on 1/29/2026 at 10:06 AM it was discovered that the resident had a care plan for a urinary catheter with interventions that included using a privacy bag initiated on 9/10/2025. During an interview with the Assistant Director of Nursing (ADON) on 2/02/2026 at 7:44 AM she confirmed that Resident #69 should have had a privacy bag covering his/her urine collection bag when he/she was at the nursing station.		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews it was determined that the facility failed to ensure Resident rooms and laundry room were kept in a clean homelike environment. This was found to be evident for 3 (Resident #7, #17, & #91) out of 9 Resident rooms and 1 out of 1 soiled laundry room observed for a clean homelike environment during the re-certification survey. The findings include: During a random observation conducted on 01/22/2026 at 10:35 AM, the Surveyor observed holes that went across the wall at the baseboard in Resident #7's bathroom. During an interview conducted on 01/22/2026 at 10:53 AM the Surveyor observed peeling paint on the wall behind Resident #17's bed. During an interview conducted on 01/22/2026 at 11:19 AM, the Surveyor observed peeling paint and holes on the wall behind the Resident's bed. During an observation conducted on 01/30/2026 at 8:23 AM, the Surveyor observed multiple brown stains on the ceiling tiles in the soiled laundry area above the washer and dryers. On 02/02/2026 at 8:32 AM the Surveyor and Maintenance Director (MD) toured the facility and observed the damaged walls in Resident #7's bathroom and Residents #17 & #91 resident rooms. The MD took notes and advised that he was not aware of the damage to the walls and stated that he would get right on it and repair the walls. The Surveyor notified the MD of the observed stained ceiling tiles in the soiled laundry room, the MD replied that he would replace the stained ceiling tiles as well.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and facility staff interview, it was determined that the facility failed to ensure the resident/resident representative received the completed bed hold notification form in writing. This was evident for 1 (Resident #101) of 2 residents reviewed for transfers during the annual recertification survey. The findings include: Bed-hold: Holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization. On 01/23/2026 at 11:14 AM, a review of Resident #101 medical record revealed that the resident was transferred to the hospital on [DATE]. There was a completed and signed copy of the notice to transfer form in the medical record dated 11/11/2025. There was a copy of a bed hold form that had the resident's name written on the form and the rest of the form was left blank. On 01/23/2026 at 11:30 AM, a copy of the bed hold form for Resident #101's transfer on 11/11/25 was requested from the Nursing Home Administrator (NHA). Brief Interview for Mental Status (BIMS): To determine the individual's attention, orientation, and ability to register and recall new information. The total possible BIMS score ranges from 00 to 15. 13-15: cognitively intact; 08- 12: moderately impaired; 00-07 severe impairment. On 01/23/2026 at 12:00 PM, the NHA provided a copy of Resident #101 bed hold form for the transfer to the hospital on [DATE]. When the NHA was questioned by the surveyor why the form was not completed in its entirety, the NHA explained that Resident #101 had a Brief Interview for Mental Status (BIMS) of 2 and was not able to sign the form. On 01/28/2026 at 11:55 AM, interview with RN #2 revealed that she does not remember the Resident. When asked what the process was for when a Resident was transferred out she stated the facility sends out copies of: face sheet, medication list, recent labs, the discharge summary, MOLST form, and transfer packet. All of the paperwork is sent with the Resident when they transfer. When questioned who fills out the bed hold policy, RN #2 stated, Unit Clerk #8 will fill out the transfer summary and bed hold if she is working. When Unit Clerk #8 is not available, then the RN will fill out the paperwork. RN #2 confirms she does not fill out the bed hold form other than the name of the Resident. She admits she has no idea how much is charged for the bed hold and does not get involved with the monetary costs for Residents. RN #2 stated she will tell the Resident representative to follow up with the business office if Unit Clerk #8 is not available to fill out the bed hold form at the time of transfer. On 01/28/2026 at 2:28 PM, The facility bed hold policy was reviewed and it was confirmed that for emergency transfers, the facility will provide a written copy of the bed hold form to the Resident / Resident representative within 24 hours. On 01/28/2026 at 3:03 PM, An interview with the Business Office Manager (BOM) revealed it is the facility's process to send the transfer summary and bed hold form in a packet of documents with the Resident when they are transferred out of the facility. The BOM then stated she would then follow up with the Resident or Resident representative with a phone call within 24-hours after the transfer and document the call and outcome in a note in the medical record. The BOM confirmed there is no note in Resident #101 medical record of a call to discuss the bed hold policy and form.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on interviews and record review it was determined that the facility failed to ensure a resident was invited and provided quarterly care plan meetings. This was evident for 2 (Resident # 7 and #61) out 2 Residents reviewed for care plan meetings during the recertification survey. The findings include: A care plan meeting is a required, periodic, interdisciplinary review where nursing home staff, residents, and families discuss and update a resident's personalized care goals, medical needs, and quality of life. These meetings occur at least quarterly or upon a significant change in condition, aiming to ensure the resident receives the highest practicable level of well-being. 1. During an interview conducted on 01/22/26 at 11:10 AM, Resident #7 reported that he/she had never received an invitation to attend their Care plan meetings. During a record review conducted on 02/01/26 at 2:55 PM of Resident #7's care conference (care plan meeting) notes, it was discovered that the resident had not received quarterly care plan meetings. The facility held a care plan meeting on 02/20/25 and 09/23/25. During a telephone interview conducted on 01/22/26 at 11:10 AM, the Social Worker reported that she believed a family member attended Resident #7's care plan meetings and confirmed that the Resident had not been invited. She also reported that she was not employed at the facility at the time therefore she was unable to explain why the Resident only had a Care Plan meeting on 02/20/25 and 09/23/25. However, since her employment she had conducted a Care plan meeting for the Resident on 12/29/25. During an interview conducted on 02/02/26 at 8:50 AM Unit Manager #11 stated that the Social Worker and the Receptionist invite the Resident to the Care Plan meetings. The nursing unit receives a list from the Receptionist for Residents scheduled for a Care Plan meeting, usually a day in advance. The Unit Manger stated that the list gave the staff notice to be able to plan ahead to have the resident up, dressed and ready for their Care Plan meeting. During an interview conducted on 02/02/26 at 9:06 AM, the Social Worker reported that she did not have a process to invite the resident to the Care Plan meeting. The Social Worker further stated that she believed the nursing staff invited the Resident to the Care Plan meetings. During an interview conducted on 02/02/26 at 9:08 AM the Nursing Home Administrator (NHA) acknowledged that the residents had not received an invitation to attend their Care Plan meeting. The NHA further reported that he planned on implementing a process to invite the Resident to their Care Plan meeting by posting an invitation card in the resident rooms. 2. During an interview with Resident #61 on 1/22/2026 at 4:37 PM he/she denied having any recent care plan meetings. During a medical record review for Resident #61 on 1/028/2026 at 9:45 AM it was discovered that Resident #61 had not had a care plan meeting since 8/12/2025 and had remained a resident in the facility. During an interview with Social Worker #9 on 1/28/26 at 2:03 PM she confirmed that Resident #61 had (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not had a care plan meeting since 8/12/2025. She advised that Resident #61 should have had one in November and was unsure of how the care plan meeting was missed.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews it was determined that the facility failed to provide services that met professional standards of practice. This was found to be evident for 2 (Resident #5& #1) out of 2 Resident reviewed for professional standards of practice during the complaint survey. The findings include: 1)During an interview conducted 01/22/26 at 12:49 PM, Resident #5 was observed grimacing. The Resident reported that he/she had stomach cramps but had not reported it to the nurse. On 01/22/26 at 1:14 PM the Surveyor reported to Registered Nurse (RN) # 2 that Resident #5 complained of stomach cramps. The RN stated that she would see if the Resident had any meds and would check on the resident. During an interview conducted on 01/22/26 at 2:16 PM, Resident #5 reported he/she had not seen the nurse and still had stomach cramps. During an interview conducted on 01/22/26 at 2:19 PM, RN #2 reported that she notified the physician with what the surveyor reported but had not checked on the resident and assessed the resident prior to notifying the physician. The RN further reported she would go and assess the resident now and update the physician. When asked if this was the RN's normal practice, to not assess a resident who complained of a medical concern prior to notifying the physician. The RN responded no. During an interview conducted on 01/22/26 at 3:22 PM, the Nursing Home Administrator (NHA) reported that it is his expectation that the nurse would assess a resident who complained of a medical concern prior to notifying the physician. 2) According to the Centers for Medicare & Medicaid Services (CMS) defines a foley catheter as a type of indwelling urinary catheter, typically made of silicone or latex, that remains in the bladder for an extended period to drain urine.During an interview conducted on 01/22/2026 at 1:58 PM, Resident #1 stated that he/she was unsure as to why he/she had a foley catheter. The Surveyor observed the foley catheter, the urine was clear, yellow, absent of sediment or hematuria (blood in urine). During a review of Resident #1's medical records conducted on 02/01/26 at 3:49 PM, it was discovered that the Resident who had a diagnosis of bladder incontinence did not have an order for a foley catheter, foley catheter care, or a care plan for the foley catheter. During the continued review of the Resident's medical records, it was discovered that there was an order for a voiding trial that stated voiding trial to begin: Clamp on for 2 hours, unclamp for 1 hour x 48 hours then remove foley. every shift for 2 Days -Start Date 01/26/2026 2300 -D/C [discontinue] Date 01/27/2026. The Minimum Data Set (MDS) is a federally mandated, standardized, clinical assessment tool for all residents in Medicare/Medicaid-certified nursing homes. It evaluates a resident's physical, psychological, and psychosocial functional capabilities. The data is used to plan care, manage quality, and determine reimbursement. During a review of Resident #1's MDS Medicare 5-day assessment dated [DATE] assessed the Resident with an indwelling catheter. During an interview conducted on 02/02/26 at 8:39 AM, the Surveyor reported that Resident #1 was unaware as to why he/she was given a foley catheter. The Surveyor also expressed concern that she was unable to determine when Resident #1 received the foley catheter, there was no record of an order for a foley catheter, foley catheter care, or care plan for a foley catheter. The Director of Nursing (DON) advised that she investigate the matter and get back to the Surveyor.On 02/02/26 at 9:18 AM the DON returned with Unit Manager #10 who reported that she reviewed the resident's hospital discharge summaries, admission notes, and progress notes and was unable to identify when and why the resident had a foley catheter. The DON acknowledged the concern.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on observation, interviews and record reviews it was determined that the facility failed to ensure Activities of Daily Living (ADL) were provided to a Resident in a timely manner. This was found to be evident for 1 (Resident #84) out of 1 Resident reviewed for ADL care during the recertification survey. The findings include: According to Centers of Medicare and Medicaid Services (CMS) Activities of Daily Living (ADLs) are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. If a sample person has difficulty performing an activity by himself/herself and without special equipment or does not perform the activity at all because of health problems, the person is deemed to have a limitation in that activity. Chuck pads are highly absorbent, waterproof, and disposable or washable under pads designed to protect mattresses, furniture, and car seats from incontinence, spills, or bodily fluids. They feature advanced moisture-locking technology, often with five-layer protection and, in some cases, adhesive strips to secure them in place for overnight use. During an observation conducted on 01/22/26 at 10:44 AM, the Surveyor observed Resident #84 in bed, heavily soiled, with large brown stains on the back of his/her night gown, chuck pad, and fitted sheet on the mattress. Some of the stains had dried circles around them which indicated the stains were not new. The Surveyor captured photographs of the stains. On 01/22/26 at 10:47 AM the Surveyor with the Director of Nursing (DON) returned to Resident 84's room. The Surveyor showed the DON the brown stains and expressed concern for the length of time the Resident was left soiled based on the dry stains. The DON observed the resident and stated looks like he/she had diarrhea and stated that she would get assigned Geriatric Nursing Assistant (GNA) #1 to have the resident cleaned and would investigate. During an interview conducted on 1/22/26 at 12:19 PM, License Practical Nurse (LPN) #7 reported that she saw Resident#84 around 7 am when she conducted a walk through. The LPN explained that her walkthrough consisted of checking to see if the resident is breathing and not in distress. She stated that her walkthrough did not consist of checking under the blankets to see if the resident was soiled. The LPN further stated that it was the responsibility of the Geriatric Nursing Assistant (GNA) to check on each resident to see if they are soiled. She reported that the dayshift GNAs are scheduled to start their shift at 6 am at which time they are expected to check each resident. A care plan is a comprehensive, person-centered document that outlines specific, measurable objectives, and timeframes to address a resident's or patient's medical, nursing, and mental/psychosocial needs. It serves as a guide for staff to manage care, incorporating goals, preferences, and necessary services to improve or maintain the highest practicable level of functioning. Pericare (perineal care) is the cleansing of a patient's genital and anal areas, essential for preventing infections, odor, and skin breakdown. It is a vital hygiene procedure for immobile, incontinent, or postoperative patients, typically performed daily during baths or after incontinent episodes to maintain comfort and dignity. During a review of Resident #84's care plan conducted on 01/30/26 at 12:30 PM, it was discovered that Resident #84 had a care plan for bowel incontinence with the following interventions: Check resident every two hours and assist with toileting as needed, Provide loose fitting, easy remove clothing, Provide pericare after each incontinent. Each of the interventions were initiated on 11/09/25. Further review of the Resident's care plan revealed a revision dated 01/29/26 to now include an intervention to Check resident after breakfast and assist with incontinent care as needed. During an interview conducted on 1/30/26 at approximately 1:00 PM, the Director of Nursing (DON) reported that she spoke with LPN #7. The LPN reported that she spoke with Geriatric Nursing Assistant (GNA) #1 who advised that she checked the resident at the beginning of her shift (6 am) and the Resident was dry.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on interviews and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice. This was found to be evident by 1 (Resident #13) out of 1 resident reviewed for quality of care. The findings include: A sit-to-stand device is a mechanical or motorized assistive device designed to help individuals with limited mobility move safely from a sitting to a standing position, or to transfer between a chair, bed, or wheelchair, while reducing physical strain on both the caregiver and the resident. A Hoyer lift is a motorized device designed to lift and transfer residents from a bed to a chair or wheelchair, or vice versa. The resident is placed in a sling, which the device then lifts, allowing for a safe transfer. This equipment helps reduce the risk of injury to both the resident and the caregiver. On 01/22/2026 at 10:19 AM, an interview was conducted with Resident #13. During the interview, the Resident reported having a recent fall. The resident stated that a Geriatric Nursing Assistant (GNA) came into the room and attempted to use a sit-to-stand machine; however, the equipment did not work. The resident reported that the GNA then attempted to transfer him/her, during which the resident fell and struck the back of his/her head. On 01/28/2026 at 11:00 AM, a record review of Resident #13's medical record was conducted. A nursing note dated 01/12/2026, written by Licensed Practical Nurse (LPN) #7, documented that Resident #13 was being transferred to the toilet when the resident slid from the toilet and struck the back of his/her head on the toilet. The note indicated that no redness or bruising was observed to the resident's head, the resident denied pain, and no injuries were noted. On 02/02/2026 at 7:02 AM, a record review of physician orders showed that, effective 09/25/2025, there was an active order for the resident to transfer with a two-person assist using a wheelchair, with a safety belt in place and proper footwear donned. On 02/02/2026 at 7:41 AM, this surveyor conducted an interview with LPN #7 regarding the fall involving Resident #13 on 01/12/2026. LPN #7 reported that she went to Resident #13's room after the incident to speak with both the aide and the resident. She stated that she was informed the aide attempted to use the sit-to-stand machine; however, the machine stopped working, possibly due to the battery losing charge. LPN #7 reported that the aide then attempted to transfer the resident independently. When asked to identify the aide involved, LPN #7 stated that she could not recall the aide's name. When asked whether the aide had obtained assistance from another staff member prior to attempting the transfer, LPN #7 reported that the aide was alone in the room and did not request assistance until after the resident had already fallen. It was asked whether use of the sit-to-stand device typically requires two staff members. LPN #7 confirmed that it does. She explained that equipment such as sit-to-stand machines and Hoyer lifts generally require two staff members to ensure resident safety and to provide assistance in the event of equipment malfunction or other unexpected issues. On 02/02/2026 at 8:02 AM, this surveyor conducted an interview with Unit Manager #11. When asked to identify the aide involved in the fall with Resident #13 on 01/12/2026, Unit Manager #11 reported that the aide was Geriatric Nursing Assistant (GNA) #27. Unit Manager #11 confirmed that following the incident, she provided education to GNA #27 and other staff regarding the requirement for two staff members to be present when using a sit-to-stand device. On 02/02/2026 at 8:09 AM, this surveyor conducted an interview with the Director of Nursing (DON). During the interview, the concern was discussed that on 01/12/2026, Resident #13 was transferred by Geriatric Nursing Assistant (GNA) #27 without assistance, which resulted in Resident #13 falling and hitting his/her head on the back of the toilet. It was explained that this was a concern because Resident #13 had an active order dated 09/25/2025 requiring transfers with a two-person assist. Additionally, interviews with other healthcare staff confirmed that use of a sit-to-stand device typically requires two staff members to safely assist with transfers. The DON confirmed that staff education was provided as a result of this incident. On 02/02/2026 at 8:23 AM, Unit Manager #11 provided documentation of the education. Record review of this documentation showed that an in-service on Transfers was conducted on 01/12/2026. The sign-in sheet for the in-service included the signature of GNA #27.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, it was determined that the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing and prevent the development of new pressure ulcers. This was evident for 1 (Resident #13) out of 1 resident reviewed for pressure ulcers. The findings include: Moon Boots are specialized protective boots designed to prevent or treat pressure ulcers on the heels. They help relieve pressure from the heels, reducing the risk of skin breakdown while the resident is in bed or seated for extended periods. A pressure ulcer is an injury to the skin and underlying tissue, usually over a bony area, caused by prolonged pressure, friction, or shearing. It can range from redness of intact skin to deep wounds affecting muscle or bone and requires proper prevention and treatment to avoid complications such as infection or delayed healing. On 01/22/2026 at 10:05 AM, an observation of Resident #13 was made in his/her room. The Resident's moon boot protector was observed sitting in the Resident's chair, and the Resident was lying in bed without a pillow under the heels to provide heel offloading. On 02/02/2026 at 8:32 AM, a review of Resident #13's orders showed that on 09/11/2025, an order was placed for Moon boots at all times while in bed for every shift for skin protection. Record review also showed that Resident #13 has a pressure ulcer of the left heel with an onset date of 09/25/2025. On 02/02/2026 at 9:18 AM, an interview was conducted with Licensed Practical Nurse (LPN) #7 regarding Resident #13. When asked if the Resident had any orders in place for pressure ulcer prevention, LPN #7 confirmed that the Resident has an order for moon boots; however, the Resident frequently refuses to wear them. LPN #7 further explained that if the Resident refuses the moon boots, staff may attempt to use a pillow to elevate the heels. On 02/02/2026 at 9:26 AM, Resident #13 was observed in his/her room sitting in his/her wheelchair. On 02/02/2026 at 10:23 AM, an observation was made of Resident #13 lying in bed without moon boots or pillows elevating the heels. Both moon boots and pillows were observed sitting in a chair next to the wall. When asked if staff had offered to have the Resident wear the moon boots or elevate the heels on a pillow, Resident #13 stated that staff did not ask. On 02/02/2026 at 10:25 AM, an interview was conducted with LPN #7 regarding this observation. She confirmed that Geriatric Nursing Assistant (GNA) #12 had assisted Resident #13 into bed. LPN #7 was informed that the Resident's feet were not elevated using the moon boots or a pillow. On 02/02/2026 at 10:26 AM, it was observed that LPN #7 spoke with GNA #12 and requested that a pillow be placed under Resident #13's feet. GNA #12 then entered Resident #13's room and positioned a pillow under the Resident's feet. On 02/02/2026 at 10:29 AM, this surveyor interviewed GNA #12 after exiting Resident #13's room. When asked if she had offered the moon boots to Resident #13, GNA #12 reported that the Resident usually does not like to wear them. When asked if she was aware of any orders for moon boots, she stated that nurses typically inform staff of resident orders. GNA #12 did not confirm whether she had asked Resident #13 about wearing the moon boots. On 02/02/2026 at 10:30 AM, an observation was made of Resident #13 lying in bed with a pillow under the feet, effectively elevating the ankles from the bed. The Resident appeared comfortable and did not report any complaints. On 02/02/2026 at 10:53 AM, an interview was conducted with the Administrator. The surveyor reported the concern that there were two separate observations of Resident #13 lying in bed without moon boots or a pillow under the ankles. It was noted that Resident #13 has an active order to wear moon boots at all times while in bed. It was further reported that Resident #13 stated staff did not ask if he/she would like to wear the moon boots. The Administrator acknowledged and understood the concern. On 02/02/2026 at 10:55 AM, an interview was conducted with Unit Manager #11 regarding the observation of Resident #13 not wearing moon boots. The surveyor explained that, even if the Resident occasionally refuses the moon boots, staff are still required to offer the moon boots or use a pillow to elevate the ankles, in accordance with the active order. Unit Manager #11 acknowledged understanding of the concern and stated she would address the issue with GNA #12.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews with facility staff, and medical record review, it was determined that the facility failed to provide respiratory care consistent with professional standards. This was evident for 2 (Residents #16 and #26) out of 2 residents reviewed for respiratory care during the recertification survey process. The findings include: On 01/22/2026 at 3:46 PM during unit rounds, the surveyor observed Resident #16 and Resident #26 receiving oxygen therapy in their rooms without an Oxygen in Use sign posted on the residents' doors. On 01/22/2026 at 4:00PM the surveyor observed an oxygen concentrator (a device that provides oxygen from room air) at the bedside of Residents #16 and #26. The oxygen concentrator humidification bottle and oxygen tubing were not labeled to indicate the date placed in use or the required replacement date. On 01/23/2026 at 7:04 AM during unit rounds, the resident #16 called the surveyor's attention and stated that the humidifier bottle contained no water and that his/her nose felt dry. The surveyor confirmed that the humidifier bottle was empty, and that the oxygen tubing and humidifier bottle were not dated. On 01/23/2026 at 7:09 AM, the surveyor notified Registered Nurse (RN) #4 and Licensed Practical Nurse (LPN) #5 at the nurses' station regarding the resident's concern. On 01/23/2026 at 9:22 AM upon follow-up, the surveyor observed that Resident #16's oxygen tubing was not dated, and the humidifier bottle remained empty and was not connected to the oxygen concentrator. Resident #16 stated that the humidifier bottle had not been changed. When asked whether nursing staff had come in to assess or address the issue, the resident stated, Nobody has been here. On 01/23/2026 10:05 AM an interview was conducted with the Director of Nursing (DON) regarding the facility's expectations for residents receiving oxygen therapy. The DON stated that oxygen tubing and humidifier bottles are expected to be dated, and that an Oxygen in Use sign should be placed on the resident's door. The surveyor informed the DON of the observations, and the DON stated, I will take care of it right now. During record review on 01/28/2026 at 11:09 AM, the surveyor noted that Resident #16 had physician orders to change the oxygen humidifier bottle and tubing weekly on Friday evenings during the evening shift, to provide continuous oxygen at 3 LPM via nasal cannula or mask for COPD with oxygen saturation monitored each shift, to pad the oxygen tubing around the ears each shift to prevent skin breakdown, and to provide 2 LPM oxygen via nasal cannula as needed for shortness of breath. On 01/28/2026 at 2:03 PM, the surveyor reviewed the facility's Oxygen Administration policy, implemented in September 2024. The policy states that the oxygen humidifier bottle must be changed when empty, every 72 hours, or according to facility policy or the manufacturer's recommendation, and that only sterile water should be used for humidification. Oxygen tubing and masks or cannulas must be changed weekly and as needed if soiled or contaminated. Additionally, an oxygen warning sign must be placed on the door of any resident's room where oxygen is in use.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on observation and interviews, it was determined the facility failed to ensure medications were accurately reconciled. This was evident for 1 of 2 medication carts observed during the annual recertification survey. The findings include: On 01/28/2026 at 10:58AM, during an observation of medication cart #1 it was determined that there was a discrepancy with the narcotic count for Resident #56 liquid morphine. The narcotic book was documented as having a count of Morphine 6.5 ml (milliliters) and the morphine bottle contained approximately 12 ml when observed by this surveyor. On 01/28/2026 at 11:10 AM, an interview with Licensed Practical Nurse (LPN) #7 verified the narcotic count for Resident #56 morphine count was approximately off by 5.5ml. LPN #7 stated she goes by the narcotic book count and subtracted administered doses from the documented count in the narcotic book. LPN #7 confirmed she had not looked at the bottle to validate if the count was accurate. During an interview conducted on 01/28/26 at approximately 12:50 PM, the Director of Nursing (DON) brought 2 bottles of morphine to the conference room where the Surveyors were located. The DON showed the Surveyors 1 unopened bottle of morphine that had a volume of approximately 18 ml however the pharmacy label showed 15 ml. The DON explained that she contacted the pharmacy for the inaccurate calibration of morphine and stated that the pharmacy would not correct the volume. The DON stated, that would explain why the volume was off with the 1 opened bottle of morphine. The opened bottle showed an approximate volume 12 ml however the narcotic count sheet showed the nurses signed off on a volume of 6.5 ml. The Surveyor expressed concern that the Resident may have not received the medication as ordered and that Licensed Nurses were signing off on an inaccurate volume and not reconciling the narcotic correctly.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, it was determined the facility failed to ensure medications were properly stored and wasted. This was evident for 1 of 2 medication carts and 1 of 1 medication storage rooms observed during the annual recertification survey. The findings include: A facility is required to secure all medications in a locked storage area and to limit access to authorized personnel. Storage areas may include, but are not limited to, drawers, cabinets, medication rooms, refrigerators, and carts. When medications are not stored in separately locked compartments within a storage area, only appropriately authorized staff may have access to the storage area. 1/28/2026 at 11:23 AM, Surveyors observed the locked medication storage room [ROOM NUMBER] with RN Unit Manager #2 the room was observed to have multiple items that were not medications stored in there: unlabeled bag for resident that contained 2 unopened beer bottles, 1 bottle of unopened alcohol, 2 unopened soda cans, and 2 magazines in foil headphones laundry detergent pads for discharged resident unlabeled bag of candy for a resident unlabeled 2 cases of soda for a resident unlabeled open bottle of wine for a resident. Several expired medications were observed in the non-secured cabinets and drawers: House stock osteo Bi-Flex 09/30/2025 House stock loperamide 2mg 08/31/2025 House stock famotidine 20mg x2 10/31/2025 House stock 5% dextrose & 0.45% Sodium Chloride x2 10/31/2025 discharged Resident #107 Albuterol sulfate neb solution 04/30/2025 Resident #8 ceftazidime 2gm/100ml 11/22/25 Resident #34's 6 medications brought in from home stored in the room in a bag that were discontinued 08/1/2025. On 01/28/2026 at 11:35 AM, an interview with Unit Manager #2 determined that items other than medication, including the several unlabeled items for Residents, were improperly stored in the medication room. The Unit Manager #2 also confirmed that 6 expired medications were stored with unexpired medications. It was also confirmed that a bag of discontinued medications for a resident were stored in the room since August 2025. Medications requiring refrigeration: some medications should be stored in the refrigerator until they are opened because cold temperatures help maintain the stability and effectiveness of their active ingredients. Improper storage can cause these medications to degrade and become less potent, which may make them ineffective. 2) On 01/28/2026 at 11:43 AM, an observation of medication cart #2 revealed discharged Resident #108's 1 vial of Lantus was improperly stored on the cart unopened and not refrigerated along with 1 vial of Lantus that expired on 11/07/25. Resident #11 was observed to have an improperly stored unopened insulin pen that required refrigeration. Observed discharged Resident #109 to have biofreeze cream on the cart. On 01/28/2026 at 11:50 AM, during an interview with RN #2, it was determined medications were stored improperly on the cart. RN #2 confirmed that unopened vials and unopened pens of insulin were marked as refrigerate until opened and were improperly stored on the medication cart. When asked about the facility's process for checking medication carts, RN #2 stated that she was not aware of a set process for how the cart was checked for expired medications, that it was up to everyone to check when they were on the cart. On 01/29/2025 at 12:55 PM, a review of the medication administration policy revealed that it is the facility process that if a medication is identified as expired, the licensed nurse will notify the nurse manager.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, record review and interviews it was determined that the facility failed to provide a therapeutic diet as ordered. This was found to be evident for 1 (Resident#1) out of 1 Resident reviewed for therapeutic diet during the recertification survey. The findings include: During a random observation conducted 02/02/26 at 8:00 AM, the Surveyor observed Geriatric Nurse Assistant (GNA) #21 deliver Resident #1's breakfast tray. The Resident complained to the GNA that he/she did not get double portions, the extra milk and cold cereal that was requested. The GNA observed the Resident's breakfast tray and agreed with the Resident. She removed the tray and stated that she would get a new tray from the kitchen. The Resident reported to the Surveyor that this happens almost every day. The Resident reported that once the tray is taken back the wait time is about 30 minutes before the correct tray is provided. A review of the resident meal ticket revealed a therapeutic diet order for mechanical soft ground and double portions. On 02/02/2026 8:19 AM this surveyor returned and observed Resident #1 attempting to eat a whole sausage patty from the new breakfast tray. The tray had 1 portion of sausage that was mechanical soft ground and 1 whole round sausage that was not mechanical soft ground. The Surveyor advised the resident that the sausage was not mechanically soft ground and that he/she should not eat the sausage. The Resident stated, it's okay the kitchen tried, I will be okay. On 02/02/2026 9:20 AM this Surveyor reported to Registered Nurse (RN) #2 that Resident #1 was attempting to eat a sausage that was not mechanical soft ground. The RN immediately went to the resident and advised he/she could eat the sausage because it was not mechanically soft ground. During an interview conducted on 02/02/26 at 10:32 AM, GNA #26 reported that she put Resident #1's original breakfast tray back in the meal cart and notified the kitchen of the missing food items. The kitchen sent a small plate that had a sausage, another carton of milk and cold cereal. The GNA stated that she put the sausage on the plate, removed the hot cereal and replaced it with the cold cereal and added the milk carton and delivered the tray to the resident. When asked if she was aware of the Resident's diet she reported no.		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record reviews and interviews it was determined that the facility failed to ensure medical records were accurate. This was evident for 1 (Resident #69) of 20 residents reviewed for accurate medical record documentation. The findings include: During a review of the Medication Administration Record for Resident #69 on 1/30/2026 at 6:38 AM it was discovered that Resident #69 had an order for: Lorazepam Oral Tablet 0.5 milligram, Give 2 tablet by mouth every 3 hours for anxiety/shortness of breath which was signed off as given on 1/30/2026 at 2:00 AM and 5:00 AM. An additional order was for Lorazepam Oral Concentrate 2 Milligram (mg) per milliliter, (mL), Give 0.5 mL by mouth every 3 hours for agitation, air hunger 0.5 mL = 1 mg which was signed off as given on 1/30/2026 at 2:00 AM and 5:00 AM. During a continued review of the orders for Resident #69 it was discovered that there was an order placed on 1/29/2026 to discontinue Lorazepam pills when liquid arrives. Do not give both the pills and liquid. It was revealed that the order for the Lorazepam pills was not discontinued after the Lorazepam Oral Concentrate arrived. During an interview with Registered Nurse (RN) #28 on 01/30/2026 at 6:51 AM he reported the liquid form of Lorazepam arrived just prior to his shift, around ten something. He advised that he had administered the liquid form of Lorazepam on 1/30/2026 at 2:00 AM and 5:00 AM to Resident #69. He confirmed that he did not administer the tablet form of Lorazepam on 1/30/2026 at 2:00 AM and 5:00 AM to Resident #69. During an observation of the Medical Administration Record (MAR) with RN #28 on 1/30/2026 at 6:56 AM he confirmed that he had documented the liquid form of Lorazepam and the tablet form of Lorazepam as being administered on 1/30/2026 at the 2:00 AM and 5:00 AM time frames. He reported he should have documented not given for the tablet form of Lorazepam. He then made a correction to the tablet form that was documented as administered on 1/30/2026 at 5:00 AM. He changed the documentation to not given and reported the reason it was not given was pills replaced with liquid Ativan. During a review of the Controlled Drug Administration Record on 1/30/2026 at 7:01 AM it confirmed that no Lorazepam tablets were administered on 1/30/2026 at 2:00 AM or 5:00 AM only the oral concentrate was given at those times. During additional review of medical records for Resident #69 on 1/30/2026 at 8:13 AM it was discovered that the order to discontinue Lorazepam pills when liquid arrives. Do not give both the pills and liquid did not appear on the Medication Administration Record (MAR) for nurse to view and sign off when completed. During an interview with the Assistant Director of Nursing on 1/30/2026 at 8:41 AM she reported the tablet form of Lorazepam should not have been signed off if they were not given, they should have been documented the tablets as not given. She confirmed that the order to discontinue the Lorazepam pills should have shown up on the MAR for nurses to see and sign off when completed, she was not sure why the order didn't show up on the MAR. During a review of the facility's Medication Administration Policy on 1/30/2026 at 11:26 AM it reported to, Sign MAR after administered and If medication is a controlled substance, sign narcotic book.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record reviews and interviews it was determined that the facility failed to have a designated Interdisciplinary Team (IDT) member for their hospice services. This was found to be evident for 1 (Resident #7) out of 1 Resident reviewed for hospice services during the recertification survey. The findings include: Hospice is a specialized, holistic, and palliative care approach for individuals with terminal illnesses typically with a prognosis of 6 months or less to live, designed to provide comfort, dignity, and pain management rather than curative treatment. It focuses on the patient's quality of life, offering physical, emotional, and spiritual support to both patients and their families, often in the comfort of home. During an interview conducted on 01/22/26 at 11:07 AM, Resident #7 advised that he/she received hospice services. During a record review conducted on 02/01/2026 at 3:19 PM, Resident #7's medical records revealed that the resident was placed on hospice on 02/17/25 with Chesapeake Hospice for heart failure. According to the Resident's medical records, the Resident was currently on hospice past the 6 months of first being admitted to hospice. During a review of Resident #7's hospice documentation conducted on 02/01/26 at 3:23 PM, the Surveyor was unable to locate the Resident's election form and recertification to continue with hospice services following the initial admission date of 02/17/25. During an interview conducted on 02/01/26 at 3:49 PM, the Director of Nursing (DON) reported that the Hospice normally does not provide the election form to the facility because the agreement is between the resident/ resident representative and the Hospice company. When asked if the facility had a designated IDT member that worked with the Hospice company, the DON stated that the Social Worker works some with Hospice. The DON advised that she would email Chesapeake Hospice to obtain documentation for the hospice services provided. On 02/02/26 at approximately 8:30 AM, the DON reported that Chesapeake responded to her email and was currently working on gathering the documentation. During an interview conducted on 02/02/26 at approximately 10:15 AM, the Nursing Home Administrator (NHA) reported that he currently did not have a designated IDT member that worked directly with Hospice on behalf of the facility. The DON returned on 2/02/26 at approximately 10:30 AM and reported that Chesapeake Hospice was faxing over 85 pages. The Surveyor was provided 67 of the 85 pages while at the facility and later the same day received the remaining 18 pages via email. On 02/03/26 at 9:00 AM the Surveyor reviewed the 85 pages and confirmed the following: recertification form dated 08/05/25 to continue with Hospice Services, an election form signed by the resident representative dated 02/17/25 and summaries of plan of care.		

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews and record review it was determined that the facility failed to ensure staff practiced infection control. This was found to be evident for 2 (Resident #9 and #69) out of 2 Residents observed for infection control during the recertification survey. The findings include: 1. During a random observation conducted on 01/22/26 at 11:39 AM, the Surveyor observed Activities Aide #25 push Resident #9 in a wheelchair down the hallway from the activities room. The Surveyor heard a dragging sound and observed the Resident's foley catheter bag dragging across the floor as the Activities Aide pushed the resident in the wheelchair down the hallway past the nursing station and to the resident's room. During an interview conducted on 01/22/26 at 11:40 AM, Activities Aide #25 reported that he had not noticed that the foley catheter bag was dragging on the floor. The Activities Aide looked at the foley catheter bag and stated oh it's on the floor, they usually hang it higher, so it does not touch the floor. During an interview conducted on 01/22/26 at 11:49 AM, the Surveyor reported to License Practical Nurse (LPN) #7 & #26 that Resident #9 foley catheter bag was observed dragging across the floor as the resident was pushed down the hallway from activities. LPN#25 reported that she would go and change the foley catheter bag due to an infection control concern. A care plan is a comprehensive, written document that outlines an individual's specific health, social, and personal care needs, along with the tailored actions, goals, and services required to meet them. It serves as an actionable roadmap for healthcare professionals and caregivers to ensure consistent,, high-quality, and personalized support, ranging from medical treatments to daily living assistance. A suprapubic catheter (SPC) is a thin, flexible tube inserted through a small incision in the lower abdomen, just above the pubic bone, directly into the bladder to drain urine, offering a long-term, more comfortable alternative to urethral catheters for chronic retention, trauma, or post-surgical recovery. They are generally replaced every 4 to 6 weeks. During a review of Resident #9's medical records conducted on 01/22/26 at 11:55 AM, it was discovered that the resident had a care plan for a supra pubic catheter with interventions initiated on 07/06/24. 2. During an observation of Resident #69 on 1/23/2026 at 12:18 PM he/she was seen sitting in front of the nursing station in his/her wheelchair with a urinary catheter drainage bag hooked to the bottom of the wheelchair and the drainage bag was lying partially on the floor. During an interview with GNA #20 on 1/23/2026 at 12:20 PM he confirmed that the drainage bag for Resident #69 should not be touching or on the floor. During an additional observation Resident #69 on 1/23/2026 at 12:35 PM his/her drainage bag was connected to the wheelchair holding it off the floor. During a review of medical records for Resident #69 on 1/29/2026 at 10:06 AM it was discovered that the resident had orders to care for an indwelling urinary catheter since 9/05/2025 and there was a care plan for a urinary catheter with interventions initiated on 9/10/2025. (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Assistant Director of Nursing on 2/02/2026 at 7:44 AM she confirmed that the drainage bag should have been kept off the floor for Resident #69.		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 02/02/2026
NAME OF PROVIDER OR SUPPLIER Solomons Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review it was determined that the facility failed to ensure education was provided to staff for the current Covid-19 vaccinations. This was found to be evident for 110 out of 110 staff employed at the facility reviewed for infection control during the recertification survey. The findings include: During a review of the staff Covid-19 vaccinations status with the Infection Control Preventionist conducted on 01/30/26 at 11:30 AM, the Surveyor was unable to locate the education for the current Covid-19 status. During an interview conducted on 01/30/26 at 11:33 AM, the Infection Control Preventionist (ICP) reported that there were only 2 staff members who had received the current Covid-19 vaccination. The ICP explained that she conducts a flu clinic for the staff that included an option for the staff to go to Walgreens to receive the current Covid-19 vaccination. When asked if the staff were provided education for the current Covid-19 vaccination, the ICP replied no, she had not provided education but going forward she would make sure she offered education to the staff.		