STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215277	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview it was determined that the facility failed to provide the required information to the resident and their representatives at the time of discharge to the hospital; and failed to ensure required documents were sent with the resident to the hospital at the time of transfer. This was found to be evident for two (Resident #6 and #9) out of three residents reviewed for hospitalization.The findings include: 1) Review of Resident #6's medical record revealed the resident was a long-term care resident who has resided at the facility for more than a year. On 2/23/26 the resident was transferred from the facility to the hospital, where the resident was admitted . Review of the progress notes for 2/23/26, including the eInteract Transfer Form, failed to reveal documentation to indicate the resident's care plan goals or current orders were sent to the hospital with the resident. On 3/5/26 further review of the medical record failed to reveal documentation to indicate a bed hold policy or written notice of transfer was provided to the resident or their responsible representative. On 3/5/26 at 2:43 PM surveyor requested the bed hold and notice of transfer information from the Medical Records Director #6 who indicated she would forward the request to the Social Service Director (SSD) #8. On 3/05/26 at 2:51 PM SSD #8 presented with the bed hold and notice of transfer documents, both dated 2/23/26. The SSD #8 reported these written notices had not yet been sent to the resident's family and indicated they were on her desk to be sent.Review of the transfer notice document dated 2/23/26, which was signed by the previous Nursing Home Administrator (NHA) #10, failed to reveal a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. 2) Review of Resident #9's medical record revealed the resident was a long-term care resident who has resided at the facility for more than 6 months. On 2/24/26 the resident was transferred from the facility to the hospital, where the resident was admitted . Review of the progress notes for 2/24/26, including the eInteract Transfer Form, failed to reveal documentation to indicate the resident's care plan goals or orders were sent to the hospital with the resident. Further review of the medical record failed to reveal documentation to indicate the bed hold or notice of transfer was provided to the resident or the resident's representative. On 3/04/26 at 4:10 PM Nurse #9 reported that when a resident is transferred out to the hospital the process includes making sure the resident and family are aware of the transfer, print out the orders, the care plan, the advance directive, the MOLST (Maryland Orders for Life Sustaining Treatment), bed hold policy and capacity paperwork. When asked for documentation to support that these items are printed out and sent with the resident, Nurse #9 reported there is the e-Interact transfer note and then a separate nurse's note. She went on to report that there are examples of this note in binders for nurses to reference. Surveyor reviewed the concern that no documentation was found to indicate care plan goals and orders were sent to the hospital with the resident. Surveyor also reviewed the concern that no documentation was found regarding the bed hold policy or notice of transfer for the 2/24/26 hospitalization.On 3/4/26 at 5:04 PM Nurse #9 confirmed no documentation (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to support that the care plan goals or orders were sent with the resident, stating that she thought it was included in the e-Interact form. Also at this time, 3/4/26 at 5:04 PM, Nurse #9 and the new Director of Nursing (DON) #7 presented with a letter that was being used for the notice of transfer. This notice failed to include several of the components required by this regulation. Nurse #9 reported they had a different version of this notice, but the previous NHA had them change it to this version.On 3/06/26 at 5:05 PM surveyor reviewed with the Nursing Home Administrator the concern regarding failure to ensure required information was sent to the hospital at the time or transfer and failure to ensure the notice of transfer and bed hold information was provided to the resident and responsible representative.On 3/06/26 at 5:29 PM the SSD #8 provided Bed Hold and notice of transfer, both dated 2/24/26, but reported that she sent this to the family yesterday or the day before. Review of the transfer notice document, dated 2/24/26, which was signed by the previous NHA #10, failed to reveal a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.

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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 observations and interviews, it was determined that the facility failed to treat residents with respect and dignity, as evidenced by failing to knock and request permission before entering residents' rooms. This was evident for 2 (Resident #79, #72) of 2 residents reviewed for dignity. The findings include:1) On 3/3/26 at 6:25 AM, Staff #2, a Geriatric Nursing Assistant (GNA), was observed by the surveyor walking into Resident #79's room without knocking on the resident's door before entering. When Staff #2 exited the room, the surveyor inquired about the resident's indwelling urinary catheter. Staff #2 returned to the resident's room with the surveyor a short time later, without knocking or announcing her intent, and showed the surveyor Resident #79's indwelling urinary catheter bag. On 3/6/26 at approximately 4:15 PM, the facility's Nursing Home Administrator and Director of Nursing were made aware of the concern. 2) On 3/4/26 at 9:01 AM, during an observation of the unit, it was noted that Resident #72 activated his/her call light for assistance. Staff #20, a GNA, entered Resident #72's room in response to the call light and asked the resident what s/he needed. However, the observation did not show that Staff #20 knocked on the resident's door or asked for permission before entering. In an interview on 3/4/26 at approximately 9:10 AM, staff #20 indicated that she usually knocked before entering residents' rooms; however, she confirmed that she had not done so and waited for permission before entering Resident #72's room during an earlier observation. During an interview on 3/6/26 at 4:53 PM, staff #7, the new director of nursing in training, stated that her expectation of staff was that they knock and introduce themselves whenever they entered residents' rooms.

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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. Based on observations, record review, and interviews, it was determined that the facility failed to provide reasonable accommodations to maintain residents' independence by failing to ensure access to remote bed controls that worked to adjust their bed settings independently. This was evident in 1 of 2 room observations.The findings include:On 3/3/26 at 8:59 AM, Resident #12 was observed lying in bed with the head of the bed elevated about 30-45 degrees and legs straight. The resident reported being stuck in that position and unable to change it because the bed remote was not functioning. The resident complained of neck and back pain due to being in that position. Resident #12 added that the staff was aware but had not taken any action to fix the remote.In a separate observation on 3/4/26 at 8:52 AM, Resident #12 was lying flat on his/her back in bed, with feet elevated higher than the head. The resident tried to lift his/her head using the remote bed control but reported that it was not working.A review of Resident #12's medical record showed that s/he was alert, oriented, and able to communicate needs. However, s/he was non-ambulatory and needed staff assistance to move.During an interview on 3/4/26 at 8:54 AM, staff #17, a nursing assistant, reported that Resident #12's remote bed control had not been working properly for some time and that staff had to use manual control at the foot of the bed. Staff #17 confirmed that Resident #12 was unable to change their position in bed due to the remote's malfunction.An interview conducted on 3/4/26 at 9:03 AM with staff #18, a maintenance assistant, indicated that Resident #12 could not operate his/her remote bed control to change positions in bed because the nursing staff had locked it. However, during an interview on 3/5/26 at 8:47 AM with staff #19, a nursing assistant, it was revealed that Resident #12's remote bed control had locked itself due to a malfunction. Staff #19 attempted to use the resident's control during the interview, but was unable to because it did not work.During an interview on 3/5/26 at 9:44 AM, the Interim Nursing Home Administrator (NHA) was in Resident #12's room with the surveyor. The NHA was observed attempting to operate the resident's bed remote control. It initially worked, but then stopped. The NHA said she would find out what was going on with it.In a follow-up interview on 3/5/26 at 10:04 AM, the NHA informed the surveyor that they had replaced Resident #12's remote bed control following the surveyor's intervention and stated that staff would continue to monitor it to ensure it remained functional.

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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 a clean, comfortable, and home-like environment for residents. This was evident in 1 of 2 rooms identified with environmental concerns during the survey.The findings include:An observation on 3/3/26 at 6:54 AM noted a strong urine odor in Resident #72's room. A follow-up observation on 3/4/26 at 9:01 AM showed that Resident #72's room still had a strong urine smell. The bathroom also had a noticeable urine odor, a sticky floor, and dark brown residue. Additionally, upon entering the bathroom, two floor tiles to the right were stained brown. The toilet bowl was heavily stained with bowel movements.During an interview on 3/4/26 at 9:26 AM, staff #21, a registered nurse, reported that the strong urine smell in Resident #72's room and bathroom had been present most of the time.In an interview on 3/5/26 at 12:07 PM, the interim nursing home administrator (NHA) was present at Resident #72's room with the surveyor. The NHA confirmed that the resident's bathroom and room had a strong urine smell; the bathroom floor had dark brown, sticky residue; and two tiles on the right side of the entrance floor had brown stains. The NHA reported that she was already aware of the concerns. During an interview on 3/5/26 at 12:17 PM with staff #22, the housekeeping manager confirmed the concerns and stated that his department's goal was to strip and deep-clean two residents' rooms weekly; however, that goal had not yet been met. He also mentioned that Resident #72's room was next on their list for deep cleaning and stripping.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review and staff interview, it was determined that the facility failed to monitor and prevent the misappropriation of resident property. This was evident for 1 (Resident #76) of 4 residents reviewed for abuse during the recertification survey.The findings include:A review of the medical record on 3/3/26 at 10:42 AM showed that Resident #76 had been at the facility since 2023. Continued review included an attending provider's order dated 2/3/25 for Resident #76 to receive oxycodone 5 mg tablets four times daily for chronic back pain. A review of facility-reported incident #2657499 involving Resident #76 found that on 10/27/25, staff #24, a licensed practical nurse, received 30 tablets of oxycodone 5mg from the pharmacy for Resident #76. Further review showed that on 10/31/25, staff #25, a registered nurse, discovered that all 30 tablets of oxycodone and the administration record sheet for Resident #76 were missing. The review also included the packing slip for the 30 5mg oxycodone pills from the pharmacy for Resident #76, which showed it was signed on 10/27/25 at 9:16 PM by staff #24, confirming that the medications were delivered and received.A review of Resident #76's medication administration record for November 2025 showed that Resident #76 did not receive his/her scheduled 5 mg oxycodone for chronic back pain on 11/1/25 at 12:00 AM, 11/1/25 at 6:00 AM, 11/2/25 at 12:00 AM, and 11/2/25 at 6:00 AM.Further review of Resident #76's medication administration progress notes for November 2025 showed that Resident #76 did not receive his/her pain medication on 11/1/25 at 12:00 AM, 11/1/25 at 6:00 AM, and 11/2/25 at 12:00 AM due to medication unavailability.During an interview on 3/6/26 at 1:27 PM, the acting director of nursing (DON) reported that her investigation revealed that staff #24 signed for the 30 pills of oxycodone 5mg for Resident #76 from the pharmacy on 10/27/25. However, staff #24 continued to deny opening the plastic bag containing the drugs. The facility was unable to locate Resident #76's pain medications that were delivered and received by staff #24 on 10/27/25. The acting DON indicated that the pharmacy delivered a new supply on 11/2/25, and the facility implemented a new process for receiving controlled medications from the pharmacy.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview it was determined that the facility failed to ensure the completion of a death in facility tracking record for a resident who expired. This was found to be evident for one (Resident #44) out of one resident reviewed for the Resident Assessment task.The findings include: Review of Resident #44's medical record revealed a Significant Change Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], was signed off as completed by Nurse #11 on [DATE]. On [DATE] further review of the medical record failed to reveal documentation to indicate another MDS assessment was completed following the [DATE] assessment. This was more than four months (which constitutes a quarter of a year) without the transmission of MDS assessment documentation.Upon entering the resident's electronic health record a notice was observed in RED which stated Death ARD: [DATE] 49 days overdue.Review of the nursing progress notes confirmed that on [DATE] the resident had expired at 2:15 AM.On [DATE] at 3:57 PM a phone interview with Nurse #11 revealed she works remotely but is responsible for ensuring the completion of the MDS assessments. In regard to tracking, Nurse #11 reported she runs a missing assessment report but confirmed Resident #44 had not come up on the report yet. Nurse #11 reported: I missed it in regard to the failure to complete the death in facility tracking assessment.

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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** Based on interviews and record reviews, it was determined that the facility failed to ensure that a resident participated in the care planning process and that interdisciplinary team (IDT) care conference meetings were conducted following completion of MDS assessments. This was evident in one (Resident#12) of three residents reviewed for care planning during the survey.The findings include:The Minimum Data Set (MDS) is a federally mandated tool that nursing home staff use to collect information about each Resident's strengths and needs. This information is then used to make care planning decisions for the Resident. The nursing home shall hold the care planning conference with an interdisciplinary team (IDT), including the attending physician, a registered nurse, a nursing aide, a dietary services representative, the Resident, and the Resident's representative (as practicable), no later than 7 calendar days after completing the MDS assessment. However, the conference may be scheduled earlier if agreed upon by the Resident, a family member, or the Resident's representative.During an interview on 3/3/26 at 8:55 AM, Resident #12 was asked whether s/he had participated in the latest care plan meeting and responded that s/he was not aware of any such meeting because s/he had not been invited. A review of Resident #12's record showed that s/he was alert, oriented, and able to verbalize needs. Continued review of Resident #12's care plan indicated that the Resident was bedfast (confined to bed due to illness) and required staff assistance with most of his/her self-care needs, including moving from one place to another.Further review included an MDS assessment dated [DATE], completed on 1/12/26, for Resident #12. Another MDS assessment dated [DATE] was completed on 2/5/26. Following the MDS completion date of 1/12/26, an IDT care plan meeting was held on 1/13/26 for Resident #12. However, the review did not show that Resident #12 attended his/her own meeting or that s/he declined to attend. A continued review of the medical record did not find documentation showing that an interdisciplinary care plan meeting also took place after Resident #12's MDS dated [DATE].During an interview on 3/4/26 at 4:13 PM, staff #8, the Social Services Director (SSD), reported that IDT care plan meetings were scheduled for Residents according to their MDS schedules, so a meeting was scheduled for Resident #12 on 1/13/26 following the 1/12/26 MDS assessment. The SSD reported that before the meeting dates, staff mailed notification letters to the residents' representatives and also handed copies to the Residents themselves. The interview also showed that, on the day of the meeting, direct care staff were informed to help facilitate residents' preparation. However, she was off work on 1/13/26. The SSD reported that, per the care conference record for 1/13/26, Resident #12 was not in attendance, and there was no documentation indicating that s/he declined to attend. In a follow-up interview on 3/4/26 at 4:56 PM, the SSD reported that no care plan meeting was scheduled after the completion of Resident #12's MDS dated [DATE].

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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. Based on medical record review and interview it was determined that the facility failed to ensure a resident's medication was obtained in a timely manner and that it was administered as ordered. This was found to be evident for one (Resident #5) out of one resident reviewed for dialysis.The findings include: Review of Resident #5's medical record revealed the resident was admitted to the facility more than 6 months ago, has a diagnosis of end stage renal disease (ESRD) and receives dialysis at a facility offsite three times a week. ESRD occurs when the kidneys are no longer functioning well enough to meet the body's needs. Treatment includes dialysis or kidney transplant. Dialysis is a treatment that filters and purifies the blood using a machine. This helps keep your fluids and electrolytes in balance when the kidneys can't do their job. Further review of the medical record revealed an order, with a start date of 7/20/25, for Renvela Oral Tablet 800 mg give 1600mg by mouth with meals for ESRD (end stage renal disease).Renvela, also known as Sevelamer Carbonate, is a medication used to control high blood phosphate levels in patients receiving dialysis.Review of a 1/3/25 memo from the pharmacy to the facility regarding phosphate binders (such as Sevelamer Carbonate) for patients with ESRD receiving dialysis revealed that, due to billing changes, it is the responsibility of the dialysis center to provide a full supply of medication to the patient for routine administration. Review of the resident's Medication Administration Record for January 2026 revealed documentation to indicate the Renvela 1600 mg was administered to the resident as ordered three times a day. No documentation was found to indicate any doses were missed in January 2026.On 3/5/26 at 3:30 PM review of the dialysis communication book for Resident #5, found at the nursing station, revealed Dialysis Communication Forms for January through March 4, 2026. Review of the communication form for 1/9/26 revealed the following notation in the portion of the form completed by nursing home staff: *Pharmacare is to send (his/her) Renvela to you!On 3/5/26 at 4:20 PM Nurse #13 confirmed that she had written the Pharmacare is to send.Renvela to you on the 1/9/26 communication form and that she had actually written the note on the evening of 1/8/26. Nurse #13 reported that there were a few days that the resident was without a supply of the Renvela, so she borrowed some from another resident's supply. She went on to report that she kept track of what was borrowed and then replaced it. Nurse #13 confirmed that the three doses of Renvela that she had documented as administered on 1/8/26 was borrowed from another resident. During the 3/5/26 interview, Nurse #13 had the resident's current supply of Sevelamer Carbonate 800 mg tablets with her. The label on the bottle was 1/12/26, indicating it was not available from the pharmacy prior to 1/12/26. Surveyor and Nurse #13 agreed there were at least 20 tablets left in the supply. The bottle indicated it initially contained 240 tablets. Nurse #13 confirmed that each dose of 1600 mg would require the administration of two tablets.Two tablets per dose, three doses per day would mean the resident should receive 6 tablets per day. That would mean 240 tablets would equal a 40-day supply. If the resident began receiving the supply on 1/12/26 the supply should have run out 40 days later, around 2/21/26.On 3/6/26 at 4:30 PM surveyor informed Corporate Nurse #14 that at least 20 pills were remaining from the 40-day supply, which, if started on 1/12/26, should have run out in February. Also reviewed the concern regarding Nurse #13's report of borrowing the medication from another resident and that other staff had documented administration between 1/9/26 - 1/12/26. Corporate Nurse #14 indicated she would investigate to see if there was another supply.Review of the 1/12/26 Dialysis Communication Form revealed the following handwritten notation: Pharmacare to send Renvela to dialysis. [S/he] is now out. If you have it please send it back c [with] [him/her].Review of the 1/16/26 Dialysis Communication Form revealed the following handwritten notation: Need [his/her] Renvela from pharmacare.Review of the February MAR revealed staff documented the Renvela as ordered three times a day except for three doses. The 2/11/26 and 2/20/26 doses due at 11:00 AM were documented with a 9 indicating it was not given and to see nursing notes; no documentation was found for the dose due at 5:00 PM on 2/17/26 as evidenced by a blank (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	space.Review of the March 2026 MAR revealed documentation that the medication was administered as ordered from 3/1 through 3/5/26.On 3/06/26 at 8:06 AM Corporate Nurse #14 reported that the amount of medication left in the supply does not account for all the doses that staff have documented as given. She reported it was documented as not given on two occasions in February which only accounts for 4 pills. Nurse #14 did not have the actual count of the pills that were left over.On 3/06/26 at 9:15 AM surveyor and Corporate Nurse #14 counted Resident #5's supply of Sevelamer Carbonate 800 mg tablets that was dated 1/12/26. A total of 63 tablets remained. Nurse #14 informed surveyor that Nurse #13 reported she had borrowed the medication from Resident #94 who has been discharged . She also confirmed that no other current resident has a supply of Sevelamer Carbonate 800 mg tablets.Review of Resident #94's medical record revealed this resident was discharged on 1/28/26 and has not returned to the facility.On 3/6/26 further review of the medical record revealed that on 3/6/26 at 11:25 AM a new order was put in placed for Renvela Oral Tablet 800 mg Give 2 tablets by mouth with meals for ESRD **2 tabs to equal 1600mg **.On 3/6/26 at 5:04 PM surveyor reviewed with the Nursing Home Administrator the concerns regarding the failure to ensure Resident #5's Renvela medication was obtained in a timely manner; failure to ensure the medication was administered as ordered and the failure to ensure professional standards as evidenced by staff borrowing medication from another resident.

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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 necessary equipment for pressure ulcer prevention was properly functioning and monitored. This was evident for 1 (Resident #8) of 1 residents reviewed for pressure ulcers. The findings include: On 03/03/26 at 7:37 AM , Resident #8 was observed while eating breakfast. The resident's bed was equipped with a pressure-reducing low air loss (LAL) mattress. The control unit setting was observed at 180 soft. Indicative for 180 pounds. On 03/03/26 at 8:27 AM, Resident #8's clinical record revealed that Staff #4, a Registered Nurse (RN), documented in the treatment administration record that the LAL mattress settings were correct for the shift on 03/03/26 at 6:30 AM. Further review of Resident #8's care plan revealed a focus for: Resident #8 having a self-care deficit related to displaced fracture of left femur, being at risk for skin impairment related to dementia, history of falls, and advanced age. The interventions documented included: Low air loss mattress: LAL mattress to bed. Check functionality and weight settings every shift. Initiated 11/27/25. On 03/03/26 at 9:06 AM , Resident #8's clinical record revealed a physician order that included:Low air loss mattress: LAL mattress to bed. Check functionality and weight settings every shift.Review of Resident #8's clinical record revealed the following most recent documented weights (in pounds):02/03/26: 106.8 (wheelchair)02/09/26: 108.4 (wheelchair)03/03/26: 110.4 (wheelchair)On 03/05/26 10:02 AM - Resident #8 was observed self-propelling in their wheelchair in the day room. The LAL mattress on the resident's bed remained set at 180 soft, consistent with the setting previously observed on 03/03/26.On 03/05/26 10:12 AM - A joint observation of the LAL mattress control unit was conducted by the surveyor and Staff #3, a Licensed Practical Nurse (LPN), on the Haven unit. The control unit setting remained 180 soft. Staff #3 was asked whether the facility had a user manual to guide staff in determining the correct LAL mattress settings. Staff #3 stated that maintenance maintains the user manual.On 03/05/26 at 10:22 AM, a review of Resident #8's clinical record revealed that Staff #3 documented on 03/05/26 at 6:30 AM that the LAL mattress settings were correct for the shift.03/05/26 11:10 AM - The facility provided the surveyor with the manufacturer's user manual for the LAL mattress. The manual instructs staff to determine the resident's weight and set the control knob to the corresponding weight setting on the control unit.At the time of the observations on 03/03/26 and 03/05/26, Resident #8's most recent documented weight was 110.4 pounds (03/03/26). The LAL mattress remained set at 180 soft, which did not correspond to the resident's documented weight.Despite this discrepancy, Staff #3 on 03/03/26 and Staff #4 on 03/05/26 documented that Resident #8's LAL mattress settings were correct when observed by the surveyor.On 03/06/26 at approximately 4:15 PM, the facility's Nursing Home Administrator and Director of Nursing were made aware of the concern.

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Mountain City Rehab Center	48 Tarn Terrace Frostburg, MD 21532

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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, record review, and interviews, it was determined that the facility failed to maintain respiratory care equipment for residents who required continuous oxygen via nasal cannula. This was evident in 1 (Resident #72) of 3 residents reviewed for respiratory care.The findings include:Humidified water is used with oxygen concentrators to provide comfortable humidity and moisture to continuous-flow oxygen therapy, preventing upper airway dryness.During an initial interview with Resident #72 on 3/3/26 at 6:54 AM, it was observed that Resident #72 was receiving 2 liters (L) of continuous oxygen via nasal cannula. The tubing or nasal cannula was neither initialed nor dated. Further observation revealed an empty humidifier canister attached to Resident #72's oxygen concentrator, dated 2/11/26.A follow-up observation on 3/3/26 at 10:40 AM showed that Resident #72 continued to receive continuous oxygen while the humidifying water canister attached to the oxygen remained empty. A review of the facility's 'Oxygen Administration policy was completed. The review included a statement: Be sure there is water in the humidifying jar and that the water level is high enough that water bubbles as oxygen flows through. A review of Resident #72's order summary as of March 3, 2026, showed an attending provider's order dated 6/28/25 indicating that Resident #72 was to receive oxygen at every shift, and that his/her oxygen tubing and humidifying bottle should be changed, dated, and initialed weekly on Wednesdays. However, an earlier observation of Resident #72's humidifier canister revealed that the last change was on 2/11/26, and the oxygen tubing was neither initialed nor dated. There was no humidifying water in the canister.During an interview on 3/3/26 at 10:45 AM, staff #23, a licensed practical nurse, was present in Resident #72's room with the surveyor. Staff #23 reported that Resident #72's humidifying water canister was overdue for a change. She stated she would replace it immediately and fill it with water. On 3/3/26 at 11:06 AM, staff #23 reported to the surveyor that Resident #72's oxygen tubing and canister had been replaced and dated after the surveyor's intervention. She also said that she filled the canister with humidifying water. During an interview with staff #7, the new director of nursing in training, on 3/6/26 at 4:57 PM, she mentioned that she expected the nurses to change the resident's canister, tubing, and humidifying water weekly before signing the task as completed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on medical record review and interview it was determined that the facility failed to ensure staff completed physical assessment of resident after they returned from dialysis treatment. This was found to be evident for one (Resident #5) out of one resident reviewed for dialysis.The findings include:The intent of this requirement is that the facility assures that each resident receives care and services for the provision of dialysis consistent with professional standards of practice including the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.Review of Resident #5's medical record revealed the resident was admitted to the facility more than 6 months ago, has a diagnosis of end stage renal disease (ESRD) and receives dialysis at a facility offsite three times a week. The resident has an order, in effect since July 2025, for dialysis Monday, Wednesday and Fridays at 11:40 AM. ESRD occurs when the kidneys are no longer functioning well enough to meet the body's needs. Treatment includes dialysis or kidney transplant. Dialysis is a treatment that filters and purifies the blood using a machine. This helps keep your fluids and electrolytes in balance when the kidneys can't do their job.On 3/5/26 review of the dialysis communication book for Resident #5, found at the nursing station, revealed Dialysis Communication Forms for January through March 4, 2026. These forms had an area at the top for nursing home staff to complete prior to sending the resident out to the dialysis center, and an area at the bottom for the staff at the dialysis center to complete. The section for the dialysis center to complete included, but was not limited to, documentation of vital signs pre and post dialysis, as well as the status of the access site, the resident's mental status , lung sounds and the presence of edema and pain. On 3/5/26 at 3:30 PM review of the Dialysis Communication Form dated 3/4/26 failed to reveal documentation from the dialysis center of the resident's status post (after) dialysis treatment. Interview at that time with Nurse #9 reported that the dialysis center fills out the bottom portion of the form and if they fail to complete that portion the nurse is supposed to call to obtain the information. Nurse #9 also reported that there is a pre and post dialysis UDA (User Defined Assessment) that facility staff are to complete on the days a resident attends dialysis. After reviewing the electronic health record, Nurse #9 confirmed that there were no follow up notes for Resident #5 for 3/4/26.On 3/5/26 at 3:42 PM surveyor reviewed the concern with the Corporate Nurse #14 the concern regarding the nursing staff's failure to follow up with dialysis after the 3/4/26 communication form failed to include documentation of the resident's status post dialysis.On 3/6/26 further review of the medical record failed to reveal documentation to indicate nursing staff completed a post dialysis assessment of the resident on 2/2; 2/6; 2/16; 2/18; 2/20 or 2/27/26. On 3/6/26 at 10:56 AM the Corporate Nurse #14 confirmed that the expectation is that nursing staff complete an assessment after returning from dialysis. Surveyor then reviewed the concern that no post dialysis UDA, or documentation of a blood pressure in the vital signs section, was found in the medical record to indicate facility nursing staff completed an assessment when the resident returned from dialysis on 2/2; 2/6; 2/16; 2/18; 2/20 or 2/27/26. On 3/6/26 at 11:24 AM Corporate Nurse #14 provided documentation to indicate facility staff followed up with the dialysis center for post dialysis information for 3/4/26. Review of the updated Dialysis Communication Form for 3/4/26 revealed a faxed date of 3/6/26 at 9:51 AM. The Corporate Nurse #14 also provided copies of the Dialysis Communication Forms for 2/2; 2/6; 2/16; 2/18; 2/20 and 2/27/26, however these forms do not include documentation to indicate an assessment was completed by facility staff after return from the dialysis center.On 3/6/26 at 1:33 PM Corporate Nurse #14 provided documentation of blood pressures in the electronic health record for the resident from 1/21/26 through 3/6/26. Review of this documentation revealed: -On 2/2/26 no blood pressure was found.-On 2/6/26 one blood pressure was recorded for 2/6/26 at 11:33 AM. -On 2/16/26 no blood pressure was found. -On 2/18/26 one blood pressure was recorded at 11:20 AM and corresponded to the blood pressure recorded by facility staff on the Dialysis Communication Form prior to being sent to dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/27/26 no blood pressure was found.On 3/6/26 at 1:33 PM the Corporate Nurse #14 confirmed that there was no additional documentation regarding assessments for facility staff post return from dialysis for the dates previously reviewed.On 3/06/26 at 5:04 PM surveyor reviewed with the Nursing Home Administrator the concern regarding the failure to ensure a resident assessment was completed after the resident returned from dialysis.

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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. Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure medications were labeled and discarded when expired. This was evident in 2 of 3 medication carts observed during medication storage and labeling inspection. The findings include:A total of 3 medication carts were inspected on 3/3/26 from 10:39 AM to 11:36 AM. 2 of the 3 medication carts had concerns identified and they were: The medication cart labeled as 100 hall 100-111 assigned to staff nurse (Nurse #5) was inspected on 3/3/26 at 10:39 AM. The inspection revealed a) an bottle of Geri-Kot (laxative) that was opened on 11/8/25 with an expiration date of 1/2026, b) Spiriva-Respimat (inhaler) for Resident #9 had no indication or label from when it was opened with instructions to discard 3 months after inserting the cartridge, and c) Breo-Ellipta (inhaler) for Resident #71 had no indication or label from when it was opened with instructions to discard 6 weeks after opening. On 3/3/26 at 10:57 AM, Nurse #5 indicated that she would discard and replace the expired laxative.Nurse #5 then stated, it's probably time to replace it. Referring to Resident #9's inhaler and indicated that a new one was also in the medication cart. However, she confirmed that the inhaler was administered earlier that day to the resident.Nurse #5 also reported that she would review Resident #71's medical record to figure out when the inhaler was opened or reorder the medication if she could not identify the open date. 2. The medication cart labeled as 300 hall 300-315 assigned to staff nurse (Nurse #4) was inspected on 3/3/26 at 11:12 AM. The inspection revealed Resident #74's Anoro-Ellipta (inhaler) that was opened on 1/12/25 with instructions to discard after 6 weeks from opening.On 3/3/26 at 11:28 AM, Nurse #4 stated, I don't think s/he's (Resident #74) on this anymore. However, after a review of the resident's administration record, she confirmed that it was administered earlier that day and indicated that she would discard the inhaler.The interim Director of Nursing (DON) was interviewed on 3/3/26 at 11:54 AM. During the interview, the concern of finding expired and unlabeled medications was discussed. The DON reported that the consultant pharmacist inspects medication carts monthly for cleanliness and ensures all medications are labeled and expired medications discarded. However, the pharmacist does not inspect all medication carts as it was done at random. The DON acknowledged the concern.

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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 interviews and record reviews, it was determined that the facility failed to offer and administer covid-19 immunization to residents. This was evident for 2 (Resident #11 and #59) of 5 residents reviewed for immunizations. The findings include:The Facility's Infection Preventionist (IP) nurse (Staff #12) was interviewed regarding immunizations on 3/6/26 at 10:27 AM. During the interview, Staff #12 explained her process and documentation. She indicated that resident immunization records are kept in the electronic health record and hard copies for consents and declination forms are kept in a binder in her office. Staff #12 then reported that she would provide the binder to the surveyor for review. While waiting for Staff #12, a review of resident electronic health records for immunizations was conducted on 3/6/26 at 10:38 AM. The review revealed the following concerns:Resident #11 had no documentation to indicate Covid-19 immunization was administered or declined in 2025.Resident #59 had no documentation to indicate Covid-19 immunization was administered or declined in 2025. The findings listed above were discussed with Staff #12 when she returned with the immunization binders on 3/6/26 at 10:56 AM. The Binders were reviewed with Staff #12 and revealed on 9/17/24, Resident #11's responsible party had given verbal consent via phone for the resident to receive 2024-2025 Covid-19 immunization. However, the bottom part of the consent had spaces with lines that was meant for documenting the administration (date, site, lot numbers, etc.) of the vaccine. This part of the document was left blank and there was no other documentation found to indicate that Resident #11 received the vaccine. On 3/6/26 at 11:09 AM, further review of the binders with Staff #12 failed to reveal any documentation that Resident #59 had received or declined the vaccine. Staff #12 reported that she recalls talking to the resident's responsible party (RP) and declining the vaccine. However, there was no declination form found or any documentation to indicate that the resident and/or resident's RP received information to decline the vaccine. The Nursing Home Administrator (NHA) was interviewed on 3/6/26 at 5:02 PM. During the interview, the concern that the facility failed to offer and provide information on Covid-19 vaccine to 2 residents was discussed. The NHA verbalized understanding and acknowledged the concern.