STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215297	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South River Rehabilitation and Wellness Center	144 Washington Road Edgewater, MD 21037

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint investigations, medical record reviews, and staff interviews, it was determined that the facility failed to ensure appropriate wound assessment and timely specialist consultation. This was evident for one of one resident (Resident #1) reviewed for pressure ulcers during this Change of Ownership (CHOW) and complaint survey. The findings include:On 5/26/26 at 11:33 AM, the surveyor reviewed complaint #3015772. It was revealed that the complainant expressed concern regarding Resident #1's wound care.A review of Resident #1's medical records revealed a history of multiple transfers and readmissions: the resident was initially admitted on [DATE], transferred to the hospital on 1/17/26, readmitted on [DATE], transferred again on 2/24/26, and readmitted on [DATE].The medical record review further revealed the following documentation gaps and discrepancies:-Initial admission [DATE] - 1/17/26): The Nursing admission Evaluation dated 1/08/26 documented that Resident #1 had pressure ulcers on the sacrum, coccyx, and groin. However, there was no follow-up documentation regarding these wounds from the contracted wound specialist (Nurse Practitioner) until the resident was transferred to the hospital on 1/17/26.-First readmission [DATE] - 2/24/26): Following readmission on [DATE], the contracted wound specialist assessed the resident on 1/27/26, with a follow-up assessment on 2/10/26. There were no wound care records for the first week of February.-Subsequent readmission and April/May Assessments: On 5/28/26 at 7:30 AM, a review of the medical records showed the wound NP evaluated the resident on 5/01/26. The NP documented a left buttock unstageable pressure ulcer measuring 4 x 4.5 x 0.3 cm and a right buttock unstageable pressure ulcer measuring 1.5 x 2.5 x 0.2 cm. Despite these severe findings, there was a total lack of specialized wound assessments during the last week of April.-Facility Assessment Discrepancies: A review of the facility's internal weekly skin assessments revealed conflicting data. The facility recorded no new skin area noted on 4/29/26, a non-pressure new area noted on 4/30/26, and no new skin issue noted on 5/07/26.During an interview with Resident #1's family member on 5/26/26 at 12:47 PM, the family member stated, [Resident #1] did not have a buttock wound during the hospital stay. No one updated us about his/her new wound.During an interview with the Director of Nursing (DON) on 5/26/26 at 1:50 PM, she explained that the facility utilizes a contracted wound care company whose Nurse Practitioner (NP) visits twice a week: on Thursdays to evaluate all new admissions (regardless of whether they have an existing wound) and on Tuesdays to follow up on residents with existing wounds. The DON also stated that the facility has a designated internal wound care nurse.The surveyor reviewed Resident #1's medical records with the DON, who validated the findings and acknowledged the lack of required wound assessments.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint investigation, a review of resident medical records, and interviews with facility staff, it was determined that the facility failed to monitor residents' nutritional status regarding body weight and failed to timely address significant weight loss. This was evident for one (Resident #1) of two residents reviewed for nutrition during this Change of Ownership (CHOW) and complaint survey.The findings include:On 5/26/26 at 11:33 AM, the surveyor reviewed complaint #3015772. It was noted that the complainant expressed concern regarding Resident #1's significant weight loss.A further review of Resident #1's medical records revealed that the resident was initially admitted on [DATE], transferred to the hospital on 1/17/26, readmitted on [DATE], transferred again on 2/24/26, and readmitted on [DATE].During a review of Resident #1's body weight on 5/26/26 at 1:00 PM, the resident's weight was noted and documented as follows:2/06/26: 171.0 lbs (pounds)3/26/26: 156.2 lbs3/27/26: 153.2 lbs4/07/26: 144.6 lbsResident #1's body weight documented on 3/26/26 was recorded 23 days after their readmission, following a 7-day hospitalization. Additionally, the weight documented on 4/07/26 reflected an 8.6 lbs loss (5.6%) within a 10-day period.During an interview with the Dietitian on 5/26/26 at 1:15 PM, she explained that facility staff are required to assess and monitor newly admitted residents' body weights weekly for four weeks, and monthly thereafter. The surveyor reviewed Resident #1's weight records with the Dietitian, who verified that there was a lack of body weight documentation following the resident's most recent readmission on [DATE]. Furthermore, the Dietitian confirmed that no interventions or follow-up care were provided regarding the significant weight loss noted on 4/07/26.On 5/26/26 at 1:50 PM, the surveyor shared concerns with the Director of Nursing (DON) regarding the lack of monitoring of Resident #1's nutritional status and body weight, as well as the lack of interventions for the significant weight loss. The DON validated the findings and acknowledged that the facility was aware of the issue.