

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2025
NAME OF PROVIDER OR SUPPLIER Anchorage Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Times Square Salisbury, MD 21801	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on a review of a complaint, record review and interview, it was determined that the facility failed to notify the Physician and the Resident representative of a change in condition and an incident that potentially required a Physician intervention. This was evident for 1 (Resident #1) of 33 residents reviewed during the complaint survey. The facility implemented effective and thorough corrective measures following the change in condition and this incident prior to the start of this survey. The facility's plan and action were verified during this survey; therefore, this deficiency was found to be Past Noncompliance with a compliance date of 2/12/25. The findings include: On 11/5/25 at 7:23 AM, a review of a Complaint #324972 indicated concerns with regard to family notification, neglect and unexpected death of the resident. A review of Resident #1's medical records revealed that on 1/3/15, Resident #1 had an abnormally high [NAME] Blood Cell count (WBC). A WBC count measures the number of these cells in the blood, which are important for fighting infection and disease. The test helps diagnose or monitor conditions like infections or inflammation. However, the facility failed to report this laboratory result to the Physician and the Resident Representative, and a change of condition report was not initiated. Further review of Resident #1's medical records revealed that Resident was on NPO diet nil per os or nothing by mouth related to difficulty swallowing. On 1/10/25, Registered Nurse (RN#28) documented that Resident #1 had a grape ice pop on his/her hand, with a large piece in his/her mouth. However, the facility failed to document this as a change in condition or incident, and neither the Physician, Nurse Practitioner, nor the Resident Representative was notified. A review of the facility's Laboratory and Radiological Services and results reporting policy indicated the following relevant items: Item III. Nurse responsibility of reporting to practitioner - Labs and /or other diagnostic results will be reviewed by a nurse before placing on/in the medical chart to determine if additional follow up is needed. Item VI. A sense of urgency is required for critical, alert, or panic values that are telephoned to the facility for laboratory services but outside vendors. The nurse will document the information and provide a read-back for accuracy. The nurse will relay the information to the supervisor. Item VII. Monitoring for effectiveness- The director of nursing and QAPI committee will be responsible for monitoring high alert lab and/or radiology results reporting for effectiveness. Notification of Change in condition- The center must inform the resident, consult with the resident's medical practitioner and/or notify the resident's representative, authorized family member, or legal power of attorney/guardian when there is a change requiring such notifications. The medical practitioner is promptly notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition. When a change in condition is noted, the nursing staff will contact the resident representative. A Quality Assessment and Performance Improvement (QAPI) meeting was held on 2/12/25. QAPI is a comprehensive, data-driven program required for long-term care (LTC) facilities that involves setting and maintaining standards and using data to continuously improve processes and outcomes to enhance the quality of life of the residents. This meeting was attended by 8 QAPI Committee members. The identified problem statements included the following: Facility failed to respond to abnormal lab timely Facility failed to notify the Physician and the Resident Representative of change in condition Facility is not following daily clinical meeting progress Facility failed to assess an NPO resident after receiving something by mouth. On 11/6/25 at 9:14 AM, the Director of Nursing (DON) was informed of these findings and confirmed that the Physician and Resident Representative were not notified, and that an incident or change in condition report was not completed. On 11/6/25 at 9:30 AM, the Administrator in Training (AIT), the Executive Director and the Regional Clinical Support Nurse were notified of these concerns and acknowledged the findings.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on a review of a complaint, record review, and interview, it was determined that the facility failed to address an abnormal laboratory result and monitor a resident for signs of aspiration following an incident that potentially required a Physician intervention. This was evident for 1 (Resident #1) of 33 residents reviewed during the complaint survey. The facility implemented effective and thorough corrective measures following this incident prior to the start of this survey. The facility's plan and action were verified during this survey; therefore, this deficiency was found to be Past Noncompliance with a compliance date of 2/12/25. The findings include: On 11/5/25 at 7:23 AM, a review of Complaint #324972 indicated concerns regarding neglect and unexpected death of the resident. A review of Resident #1's medical record revealed that on 1/3/15, Resident #1 had an abnormally high [NAME] Blood Cell count (WBC). A WBC count measures the number of these cells in the blood, which are important for fighting infection and disease. The test helps diagnose or monitor conditions like infections or inflammation. However, the facility failed to document a change of condition. Further review of Resident #1's medical records revealed that the resident was on NPO diet nil per os or nothing by mouth related to difficulty of swallowing. On 1/10/25, Registered Nurse (RN#28) documented that Resident #1 had a grape ice pop on his/her hand, with a large piece in his/her mouth. However, no evidence indicated that a change in condition was also documented nor a monitoring for signs of aspiration was initiated. A Quality Assessment and Performance Improvement (QAPI) meeting was held on 2/12/25. QAPI is a comprehensive, data-driven program required for long-term care (LTC) facilities that involves setting and maintaining standards and using data to continuously improve processes and outcomes to enhance the quality of life of the residents. This meeting was attended by 8 QAPI Committee members. The problem statement identified that the Facility failed to respond to abnormal lab timely and Facility failed to assess an NPO resident after receiving something by mouth. On 11/6/25 at 9:14 AM, the Director of Nursing (DON) was informed of these findings and confirmed that an incident or change in condition report was not completed. On 11/6/25 at 9:30 AM, the Administrator in Training (AIT), the Executive Director and the Regional Clinical Support Nurse were notified of these concerns and acknowledged the findings.</p>		