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 03/20/2026
NAME OF PROVIDER OR SUPPLIER Anchorage Rehabilitation and Wellness 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of all pertinent administrative documents and a closed record, and staff interview, it was determined that the facility failed to notify Resident #1's physician and representative immediately after a significant change in condition occurred. This was evident for 1 (Resident #1) of 8 residents reviewed during a complaint survey. The findings include: On 02/18/26 the Office of Health Care Quality received a complaint with concerns that Resident #1 was not provided with quality of care. A review of the facility policy Notification of Change in Condition on 03/19/26 revealed Compliance Guidelines indicating the center must inform the resident, consult with the resident's medical practitioner and/or notify the residents' representative, authorized family member, or legal power of attorney/guardian when there is change requiring such notification. (Circumstances requiring notification including but not limited to): 2. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status including but not limited to clinical complications or life-threatening conditions. Resident #1 was admitted to the facility on [DATE] with diagnoses that include but not limited to morbid obesity, Type II diabetes, Stage 5 chronic kidney disease, stroke with left sided weakness, polyneuropathy, anemia in chronic kidney disease, hyperlipidemia, dementia, Vitamin D deficiency, GERD, arthritis due to Lyme disease. The BIMS (Brief Interview for Mental Status) score is a 0-15 point tool used in healthcare, particularly long-term care, to assess cognitive function, with higher scores indicating better cognition. It evaluates immediate recall, temporal orientation, and short-term memory. A score of 13-15 indicates intact cognition, 8-12 moderate impairment, and 0-7 severe impairment. On 11/19/25, the facility staff obtained a BIMS score of 6/15 on Resident #1. Review of Resident #1's closed medical record on 03/19/26 revealed the following documented weights for Resident #1: 12/5/2025 16:14 = 199.3 pounds, Wheelchair1/2/2026 12:54 = 183.0 pounds, Wheelchair1/3/2026 12:54 = 183.5 pounds, Wheelchair, a 7.9 % weight loss.In an interview with the facility Dietician on 03/19/26 at 12:03 pm, the facility Dietician stated that the facility electronic medical charting system will send an alert to all department managers regarding a resident's changes in condition. Significant weight loss is considered and alert item. Resident #1 was identified and confirmed with a significant weight loss on 01/03/26 with a 7.9% (15.8 pounds) weight loss in 1 month. The facility Dietician stated that another staff member cleared the 01/03/26 weight loss change alert for Resident #1 and the department managers and Resident #1's physician were not immediately made aware of the significant weight loss. The facility Dietician stated that they are the only person now in the facility to clear a significant weight change alert for a resident.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of all pertinent documents and a closed medical record, and interviews with facility staff, it was determined that the facility failed to provide updated non-pressure wound assessments, failed to identify a new wound on the left great toe. This delayed the treatment for an infected wound. This was evident for 1 (Resident #1) of 2 residents reviewed during a complaint survey. The findings include: On 02/18/26 the Office of Health Care Quality received a complaint with concerns that Resident #1 was not provided with quality of care. The complaint indicated Resident #1 was sent to the hospital on [DATE]. After further medical evaluation and treatment at the hospital, it was ultimately determined that Resident #1's condition had deteriorated to the extent that amputation of her left leg, below the knee, was medically necessary. The procedure was performed on February 6, 2026, to preserve Resident #1's overall health and quality of life. Resident [NAME] was admitted to the facility on [DATE] with diagnoses that include but not limited to morbid obesity, Type II diabetes, Stage 5 chronic kidney disease, stroke with left sided weakness, and dementia. On 02/28/2025, physician orders instructed the nursing staff to perform weekly skin assessments. Documentation to be completed on a Weekly Skin Assessment, once a day, every Monday for skin assessment. On 12/30/2025, at approximately 1:50 PM, a staff member alerted third floor unit manager, LPN#1, about Resident #1's left great toe/feet. LPN#1 documented observing a 0.5 cm diameter open area just under the left great toenail. There were no indications of pain in the toe/foot at the time of the change in condition. LPN#1 notified Resident #1's physician and family member about the change in condition. Lab work, a venous doppler, and dressing care were ordered by Resident #1's. The nursing staff were instructed to cleanse the left great toe wound with wound cleanser, apply a betadine wet to dry dressing, and cover with a band aid every shift. On 12/30/2025 at 9 am, LPN#1 completed an assessment form that triggered a skin change in condition. The Skin change form indicated a Braden Observation tool, a Pain Observation tool, and a Skin Grid (Pressure and Non-Pressure) tool should be completed and placed in the resident's record. Further review failed to reveal whether any of these 3 assessment forms had been completed. On 12/31/2025, the results of Resident #1's left lower leg doppler were reported to the facility staff. The doppler results indicated: Mild peripheral vascular disease (PAD) suspected without occlusion, left lower extremity. A review of Resident #1's January 2026 the nursing Weekly Skin Integrity Review revealed no mention of Resident #1's left great toe wound improving or deteriorating or any measurements or descriptions of the left great toe wound. This was true for the next three weeks. LPN#2 documented on 01/05/2026 at 7:26 pm that there were no skin areas. On 01/12/2026 at 10:14 am, LPN#3 documented there were no skin areas since the last documented skin check. On 01/19/2026 at 10:29 am, RN#1 documented that there was a skin area, but there was no attached assessment of Resident #1's left great toe. On 01/26/2026 at 3:20 PM, RN#4 documented that Resident #1's left great toe was now observed to be swollen, red, warm, and tender to touch. Resident #1's left great toenail was observed no longer attached to the toe and the skin encompassing the toenail was off as well. Areas of dark discoloration were documented surrounding the left toes. On 01/26/2026, RN#4 notified the Skin and Wound Consultant, CRNP#1, to assess Resident #1's left foot wound. In an interview with RN#4 on 03/20/26 at 10:48 am, RN#4 stated that they were alerted to Resident #1's left foot on 01/26/26 during the day. RN#4 stated that Resident #1's foot had deep purple to black marks around the left toes. RN#1 stated that Resident #1 had not been receiving wound care to the left foot from the facility wound care consultant in January 2026. RN#4 stated the facility does not have a wound team/nurse. RN#4 stated the expectation for any new wound found on a resident is that the nursing staff will care for each resident's wound. It is also the responsible for the nurse on the unit to assess, document the wound characteristics, and notify the resident's physician. Further review of Resident #1's closed medical record revealed that CRNP#1 documented Resident #1, nor the facility nursing staff knew when the left great toe first (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appeared or what caused the new wound. CRNP#1 documented Resident #1's left great toenail has been removed with a large sheet of skin peeling off entire distal left great toe. Resident #1 denied pain to the area. CRNP#1 wound assessment indicated the left great toe had Cellulitis (infection), was a new Full Thickness wound (Full-thickness wounds are severe injuries that destroy both skin layers (epidermis and dermis) and extend into subcutaneous fat, muscle, or bone, commonly resulting from deep burns or severe pressure ulcers. Symptoms include a dry, leathery, or charred appearance, often with white or brown color, and frequently lack pain due to nerve destruction). CRNP#1 also indicated the new left great toe wound had no odor, measured 2.1 cm x 6 cm x 0.3 cm, had exposed dermis and subcutaneous tissue exposed. The wound was unattached and was draining a moderate amount of serosanguineous drainage (Serosanguinous drainage is a thin, watery, pink-to-light-red fluid common in healing wounds, especially 2-3 days post-surgery or injury. It is a mixture of serum (clear, yellow plasma) and sanguineous (bloody) fluids, indicating that minor capillary bleeding is occurring alongside normal healing processes). CRNP#1 cleansed Resident #1's left great toe wound, placed a dressing on the foot in preparation to be transferred to the hospital. In an interview with CRNP#1 on 03/18/26 at 3:51 pm, CRNP#1 stated that they were first alerted to Resident #1's left great toe wound on 01/26/26. In the past, CRNP#1 stated that they were alerted to any new resident wounds by the nursing staff adding the resident's name to the wound care book that is located on every nursing unit. CRNP#1 did not recall being alert to Resident #1's left great toe wound this way. Care Plan Review for Resident [NAME] on 03/18/26: On 11/05/2024, the nursing staff initiated a care plan for Resident #1 being at risk for skin integrity issues. During the complaint review, the surveyor reviewed Resident #1's care plans and found no updates in any care plan or found a new care plan related to Resident #1's non-pressure wound of the left great toe that was first identified on 12/30/25. A review of Resident #1's hospital record on 03/20/26 revealed that Resident #1 was admitted to the hospital on [DATE] for MRSA (type of infection) bacteremia secondary to a left foot wound. A Vascular Surgery physician was consulted and determined Resident #1 did not have any options for opening the arteries to the left foot. Resident #1 underwent left leg below the knee amputation on 02/06/2026.