STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215033	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levindale Hebrew Ger Ctr & Hsp	2434 West Belvedere Avenue Baltimore, MD 21215

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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 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. 44440 Based on review of the facility's investigation file, review of medical records and interviews, it was determined that the facility failed to honor and respect a resident's wishes for Activities of Daily Living (ADL) cares. This was found evident in 1 (Resident #77) of 3 residents reviewed for Resident rights. The findings include: On 10/29/24 at 9:03 AM, the surveyor interviewed Resident #77. During the interview Resident #77 was able to answer questions by nodding, mouthing answers and using electronic devices to communicate. During the interview Resident #77 confirmed that a Geriatric Nursing Assistant (GNA) held him/her down and continued to perform cares that he/she had expressed he/she did not want or need to be performed. Resident #77 further communicated that he/she had not seen that GNA since the incident. On 11/13/24 at 1:12 PM, the surveyor reviewed Resident #77's medical record. The review revealed that Resident #77 was assessed as cognitively intact on 8/21/24 with a Brief Interview for Mental Status (BIMS) score of 15. Resident #77's Decision Making Capacity and Treatment Limitation form dated 11/18/23 documented yes to all three competency ability questions, deeming Resident #77 capable of making his/her own medical decisions. On 11/13/24 at 1:38 PM, the surveyor reviewed the facility's investigation file into the alleged abuse of Resident #77 by GNA #33. The surveyor reviewed the statement written by GNA #33. GNA #33 stated that on the day of the alleged incident she was told by other staff that Resident #77 was resistant to cares and that he/she should be checked even if the resident refused. She further wrote when she went into Resident #77 room and told him/her that she was there to check for him/her for incontinence, Resident #77 communicated that he/she did not want to be checked or changed. GNA #33 instructed Resident #77 that the other GNAs and nurses told her she needed to check for incontinence. GNA #33 next stated that Resident #77 held his/her cover so tight to his/her neck she was not able to pull the covers back. After this GNA #33 decided to pull the covers up from the foot of the bed and hold Resident #77's arm across him/her. On 11/14/24 at 7:09 AM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed that GNA #33 was suspended and was placed on the do not return list to the facility. The DON agreed that the GNA should have respected Resident #77 request to not have the ADL cares performed and honor his/her rights to refuse.

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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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 44440 Based on record review, and interviews it was determined that the facility failed to notify the Resident's health care Responsible Party (RP) of a change to the Resident's plan of care and the facility failed to provide a Resident's Representative/guardian the right to be involved in the care planning process. This was found evident in 2 (Resident #51 and #40) of 3 Residents reviewed for resident rights. The findings include: 1. On 10/30/24 at 12:59 PM, the surveyor reviewed Resident #51's paper medical record. The review revealed that on 3/3/21 Resident # 51 was deemed not to have the capacity for decision making capacity for medical treatments. On further review it was noted that Resident #51's daughter was the Responsible Party (RP) for Resident #51. On 11/7/24 at 1:36 PM, the surveyor reviewed Resident #51's electronic medical record. The review revealed a change of condition evaluation written on 8/20/24. The evaluation noted a new skin tear on Resident #51. At the end of the report the section titled, Resident Representative Notification had a statement; Name of the family/resident representative notified. The respective answer was documentation as self. On 11/7/24 at 12:09 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated that the RP should have been notified of the new skin condition and she would look for documentation to support the RP was notified. On 11/7/24 at 1:33 PM, the surveyor conducted a follow-up interview with the DON and at this time the DON confirmed she could not provide documentation that the RP was notified. 2. On 10/30/24 at 1:07 PM, the surveyor reviewed Resident #40's paper medical record. The review revealed documentation dated 1/21/19 that established Resident #40 had co-guardians. On 11/1/24 at 1:32 PM, the surveyor reviewed Resident #40's electronic medical record. The review revealed that on 2/14/24 and 10/30/24 Social Worker Staff #30 documented a care plan meeting was held and the family was in attendance for Resident #40. However, a care plan meeting note written by Staff #30 dated 7/17/24 stated Staff #30 left a detailed voice message for Resident #40's son pertaining to Resident #40's care plan. On 11/6/24 at 10:30 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated that Resident #40 did not have his/her care plan in June of 2024 due to being hospitalized . The surveyor asked if the family was invited or in attendance for the July 2024 care plan meeting that was held. The DON stated she would look into the concern and follow up. On 11/6/24 at 11:58 AM, the surveyor conducted a follow-up interview with the DON. The DON confirmed that there was no documentation that the family was invited or in attendance of the care plan meeting that was held in July of 2024.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 45733 Based on record review and interview, it was determined that the facility failed to maintain a proper resident's Advance Directives in the Resident's medical record and/or offer to formulate one. This was found to be evident for 2 (Residents #32 and #49) out of 7 residents reviewed for the Advance Directives during the annual survey. The findings include: An Advance Directive is a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions because of a serious illness. An Advance Directive may also give a person (such as a spouse, relative, or friend) the authority to make medical decisions. 1a) Record review, on 10/31/24 at 1:03 PM, revealed that Resident 32's Medical Orders for Life-Sustaining Treatment (MOLST) certification stated that his/her Advance directives was selected on 8/5/24 by Nurse Practitioner Staff #42. However, no Advance Directives document was found. During the interview, on 10/31/24 at 2:17 PM, the Director of Social Service Staff #6 stated that Advance Directives information was built into the facility's internal face sheet section under the legal contact person. She stated there was no need to maintain proper Advance Directives records. Staff #6 was informed that she failed to comply with and implement the MOLST certification/order to obtain a proper Advance Directive to direct Resident #32's life-sustaining treatments. During an interview, on 11/1/24 at 11:09 AM, the Director of Nursing (DoN) reviewed the above-mentioned deficiency concerns. The DoN agreed that a copy of the Advance Directives should be on file either in the floor chart or in the electronic record. After the surveyor's intervention, the DoN later presented a copy of the Advance Directives that she had obtained from the hospital's record. 44440 1b) On 10/30/24 at 12:55 PM, the surveyor reviewed Resident #49's paper medical record. The review revealed that Resident #49 was deemed to have capacity to make medical decisions for him/herself. On 11/8/24 at 7:27 AM, the surveyor reviewed Resident #49's electronic medical record. The review revealed a psychosocial assessment was completed on 5/14/20 and noted that Resident #49 did not have advanced directives. A box was checked that stated, resident/family had been informed of surrogate decision making regulations. On further review a progress note was written by Social Worker Assistant Staff #30 on 9/11/24 stated that Resident #49 requested information about advanced directives be sent to his/her mother. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 9:19 AM, the surveyor interviewed the Director of Social Service Staff # 6 and the Director of Nursing (DON). The surveyor asked how the facility determines if the Resident has advanced directives. Staff #6 stated during the psychosocial history assessment advanced directives are addressed. The surveyor asked if Resident #49 was offered to make advanced directives on 5/14/20 when his/her psychosocial assessment was completed it was noted that Resident #49 did not have any advanced directives. Staff #6 stated because there is no area on the psychosocial history assessment to indicate if advanced directives were offered to be formulated, she is unclear if Resident #49 was offered the opportunity to create one on 5/14/20 when it was identified that Resident #49 did not have one.

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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. 44440 Based on record review and interviews it was determined that the facility failed to inform the Resident's primary care physician of the need to alter treatment. This was found evident of 1 (Resident #51) of 2 residents reviewed for change of condition. The findings include: On 11/7/24 at 11:04 AM, the surveyor reviewed Resident #51's medical record. The review revealed that Resident #51 was admitted to the facility in early 2021. On admission Resident #51 had a percutaneous endoscopic gastrostomy (PEG) tube (a feeding tube that is inserted through the skin and into the stomach to provide direct access to the stomach). The PEG tube was used to provide tube feeding for Resident #51. On further review the surveyor noted Resident #51 had vomited on 10/1/24, 10/10/24, 10/11/24, (an X-ray was ordered) 10/13/24 (tube feed held),10/17/24 (tube feed held for 2 hours),10/18/24 (tube feed held for 2 hours) with notation provided notified, 10/19/24 2 (tube feed held for 2 hours), 10/21/24, 10/23/24 (tube fee on hold), 10/27/24,10/31/24 (tube feed held for 2 hours) and on 11/2/24. The surveyor reviewed the orders. 10/18/24 and 10/24/24 were the only two days where orders were written to hold or restart the tube feeding. The surveyor reviewed the Tasks documentation for bowel regimen notation. The review revealed Resident #51 had no bowel movement documented from 10/16/24-10/21/24 and none from 11/1/24-11/6/24. Review of the facility policy titled: Bowel Assessment and Management revealed that if a resident does not have a bowel movement within 48 hours an order should be obtained from a physician to initiate a bowel protocol or other alternative bowel management treatment. On 11/8/24 at 6:30 AM, the surveyor reviewed a progress note written by Physician #20. The note was written after a follow-up visit on 11/7/24. Staff #20 documented that Resident #51 was noted to have been given Zofran (a medication given to help with nausea) and also vomited on 11/6/24. The note further stated that Resident #51 is likely constipated due to his/her bowel movement was last recorded on 10/31/24. A new bowel regimen was ordered. On 11/14/24 at 9:42 AM, the surveyor interviewed Staff #20 along with the Director of Nursing (DON). During the interview Staff #20 stated that Resident #51 has had chronic vomiting. She further stated that sometimes his/her coughing could lead to vomiting and that the vomiting is not always gastrointestinal related. The surveyor asked Staff #20 if she was aware of the number of episodes of vomiting, the number of times tube feeding that were held and the two times Resident #51 went 6 days without a bowel movement in the last two months. Staff #20 stated she discovered the 6 days without a bowel movement on her visit on 11/7/24 but was not informed of the days in October. She further stated she was not notified of all of the vomiting episodes or the number of times the tube feeds were put on hold. She further stated she would have liked to have been notified of these episodes.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 44440 Based on review of the facility's investigation report, record review, and interviews, it was determined that the facility failed to protect a resident from being physically restrained by an employee. This was found evident on 1 (Resident #77) of 7 Residents reviewed for abuse. The findings include: On 10/29/24 at 9:03 AM, the surveyor interviewed Resident #77. During the interview Resident #77 was able to answer questions by nodding, mouthing answers and using electronic devices to communicate. During the interview Resident #77 confirmed that a Geriatric Nursing Assistant (GNA) held him/her down and continued to perform cares that he/she expressed he/she did not want or need to be performed. Resident #77 further communicated that he/she had not seen that GNA since the incident. On 11/13/24 at 1:12 PM, the surveyor reviewed Resident #77's medical record. The review revealed that Resident #77 was assessed as cognitively intact on 8/21/24 with a Brief Interview for Mental Status (BIMS) score of 15. On 11/13/24 at 1:38 PM, the surveyor reviewed the facility's investigation file in the alleged abuse of Resident #77 by GNA #33. The surveyor reviewed the statement written by GNA #33. GNA #33 stated that on the day of the alleged incident she was told by other staff that Resident #77 was resistant to cares and that he/she should be checked even if the resident refuses. She further stated when she went into Resident #77's room and told him/her that she was there to check for incontinence Resident #77 communicated he/she did not want to be checked or changed. GNA #33 instructed Resident #77 that the other GNAs and nurses told her she needed to check for incontinence. GNA #33 next stated that Resident #77 held his/her cover so tight to his/her neck she was not able to pull the covers back so she pulled the covers up from the foot of the bed and held Resident #77's arm across him/her. On 11/14/24 at 7:09 AM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed that GNA #33 was suspended and was placed on the do not return list to the facility. The DON agreed that Resident #77 should not have been held down by GNA #33.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49815 Based on facility staff interview and medical record review it was determined that the facility failed to provide notification to the Ombudsman of the residents that transferred to the hospital. This was found to be evident in 2 (#191 & #30) out of 3 residents reviewed for hospitalization s. The findings include: 1a) On 11/1/2024 at 11:30 AM the surveyor reviewed Resident #191's closed medical record. Review of the medical record revealed that Resident #191 was transferred to the hospital on 7/20/2024 and 7/29/2024. In an interview at 8:55 AM on 11/4/2024 the surveyor requested from the Director of Nursing (DON) the documentation of the Ombudsman notification for Resident #191's transfers to the hospital on 7/20/2024 and 7/29/2024. The DON stated to the surveyor that the facility does not provide notification to the Ombudsman when a resident is transferred to the hospital and that she would follow-up with the Nursing Home Administrator (NHA). At 9:32 AM on 11/4/2024 the surveyor interviewed the Nursing Home Administrator (NHA) for documentation of Ombudsman notification for Resident #191's transfers to the hospital on 7/20/2024 and 7/29/2024 and asked what the expectation was for Ombudsman notification of Resident transfers to hospital. The NHA stated that he was responsible for Ombudsman notification of Resident transfers to hospital and discharges. The NHA stated that the Ombudsman notification was done for the 7/29/2024 transfer of Resident #191 to the hospital, but the Ombudsman notification for the 7/20/2024 transfer of Resident #191 to the hospital was not done because the Resident was going to return to the facility. Additionally, on 11/4/2024 the Nursing Home Administrator (NHA) provided the surveyor with an email that he sent to the Ombudsman on 8/5/2024 at 9:49 AM and a computer-generated report titled Discharges 7/1/2024 to 7/31/2024 from the facility's clinical documentation system. This email that the Nursing Home Administrator sent to the Ombudsman included Residents who were discharged for the month of July 2024, and Resident #191 was included in this report for transfer to the hospital on 7/30/2024, but Resident #191 was not included in this report for the transfer to the hospital on 7/20/2024. The surveyor conveyed this to the Nursing Home Administrator. The NHA acknowledged the surveyor and did not provide any additional documentation. 50385 1b) On 10/29/24 at 9:14 AM, Resident #30 was interviewed. When asked if they had been hospitalized recently, they stated once this year for sepsis from a [Urinary Tract Infection (UTI)]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 10:28 AM, a review of Resident #30's records was conducted. The resident was sent out to hospital on 4/20/24. The resident has history of UTIs and had received antibiotics prior to hospitalization . A provider's progress note from 4/18/24, prior to hospitalization , states: Pt is seen today for follow up of dysuria, choking episodes, and chronic pain. S/he recently completed a course of cefuroxime [an antibiotic] (4/4-4/11/24) for UTI. S/he reports that it didn't help because s/he still has dysuria. Ordered repeat [Urinalysis] and urine culture. On 11/06/24 at 10:51 AM, an interview was conducted with Administrator (Staff #1). When asked if the Ombudsman was notified of Resident # 30's transfer to the Hospital on 4/20/24, Staff #1 stated, it does not appear that the resident was included in the report [a report of discharges and transfers in the month of April sent to the Ombudsman]. We know it's something we should be doing, and we have changed the way we manage transfers to hospitals so the Ombudsman can be notified. Staff #1 provided this surveyor a copy of the report of resident transfer and discharges that was provided to the Ombudsman.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 44440 Based on medical record review, and interviews it was determined the facility failed to provide the Resident and/or Representative with a written notice of the facility's bed hold policy upon transfer to an acute care facility. This was evident for 1 (Resident #21) of 3 residents reviewed for hospitalization . The findings include: On 11/6/24 at 11:07 AM, the surveyor reviewed Resident #21's medical record. The review revealed that on 7/14/24 and 8/1/24 Resident #21 was sent out to the hospital. An e-interact note dated 8/1/24 stated Resident #21's legal guardian was notified by the on-call provider of the transfer. No documentation was noted on 7/14/24 or 8/1/24 that the bed hold policy was given to the legal guardian. On 11/6/24 at 2:09 PM, the surveyor interviewed the Director of Nursing (DON). The surveyor asked the DON if the facility provided the bed hold policy to Resident #21's legal guardian related to the transfers on 7/14/24 and 8/1/24 of Resident #21 to the hospital. The DON stated the facility would send the bed hold policy in a packet to the hospital and would also mail the policy to the Responsible Party or guardian. The DON confirmed the facility had no documentation to support that these processes happened for Resident #21's transfers.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on facility staff interview and medical record review, it was determined that the facility failed to accurately document Resident assessments on the Minimum Data Set (MDS) assessment as evidenced by inaccurate coding for Residents. This was found to be evident for 4 (Resident #191, #11, #164 and #40) out of 73 Residents reviewed on the survey. The findings include: The Minimum Data Set (MDS) is a health status screening and assessment tool used for all Residents of long-term care nursing facilities. The MDS is part of the federally mandated process for clinical assessment of all Residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each Resident's functional capabilities and helps nursing home staff identify health problems 1a) The surveyor conducted a record review of the closed medical record for Resident #191 on 11/1/2024 at 9:10 AM. The review revealed documentation in the progress notes that Resident #191 was transferred to the hospital on 7/29/2024 at 19:15 PM. Further review of the medical record on 11/1/2024 revealed that Resident #191 had a 7/30/2024 Discharge - Return Not Anticipated Minimum Data Set (MDS) assessment completed by the facility staff. The surveyor interviewed the Director of Clinical Reimbursement #21 on 11/18/2024 at 10:00 AM. The surveyor conveyed to the Director #21 that Resident #191 was discharged to the hospital on 7/29/2024 as documented in the progress notes, but the MDS assessment was coded as Resident #191 discharged to the hospital on 7/30/2024. Director #21 stated that she would review Resident #191's Discharge MDS and hospital records and follow up with the surveyor. At 12:32 PM on 11/18/2024 a follow-up interview was conducted with the Director of Clinical Reimbursement #21. Director #21 stated that Resident #191 did transfer and was admitted to the hospital on 7/29/2024, and that she completed a modification to the 7/30/2024 Discharge MDS. Director #21 provided the surveyor with the modified Discharge MDS coded with the accurate discharge date of [DATE]. 1b) An indwelling catheter is a thin, hollow tube that is inserted into the bladder to drain urine. It is also known as a Foley catheter. An ostomy is an opening (stoma) from an area inside the body to the outside of the body. The surveyor conducted a record review of the closed medical record for Resident #11 on 11/1/2024 at 11:31 AM. Review of the 12/21/2023 Significant Change MDS assessment revealed that Resident #11 had an indwelling catheter and did not have an ostomy. Further review of the 12/21/2023 MDS revealed that Resident #11 for urinary continence was coded as always incontinent and for bowel continence was coded as Not rated. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/2024 at 10:00 AM the surveyor interviewed the Director of Clinical Reimbursement #21. The surveyor conveyed to the Director #21 that Resident #11 had indwelling catheter coded as Yes but urinary continence coded as always incontinent, and ostomy coded as a No, but bowel continence coded as Not rated on the 12/21/2023 Significant Change MDS assessment. Director #21 acknowledged the inaccurate coded MDS assessment and stated to the surveyor that she would correct and complete a modification to the 12/21/2023 Significant Change MDS for Resident #11. At 12:32 PM on 11/18/2024 a follow-up interview was conducted with the Director of Clinical Reimbursement #21. Director # 21 stated that she completed a modification to the 12/21/2023 Significant Change MDS and provided the surveyor with a copy of the modified MDS assessment for Resident #11 coded with the accurate assessments for catheter, ostomy, and urinary and bowel continence. 45733 1c) During the interview, on 10/29/24 at 1:12 PM, Resident #164 stated that an accident knocked his/her front teeth out almost [AGE] years ago. Visibly this resident's front upper and lower teeth were missing and the resident had no dentures. Further record review revealed that on 2/12/ 2024 at 3:49 PM the MDS coordinator Staff #40 coded section L0200D in the MDS, No for obvious or likely cavity or broken natural teeth. During the interview, on 11/06/24 at 3:14 PM, the Director of Nursing reviewed the MDS record as above for miscoding and she was made aware of the concern that the initial MDS's full assessment did not code that and noted the upper and lower front natural teeth were missing. 44440 1d) On 10/29/24 at 12:05 PM, the surveyor observed that Resident #40 had no splints on and had bilateral (both) contracted hands. On 11/13/24 at 9:45 AM, the surveyor conducted an interview with the Rehab Manager Occupational Therapist (OT) Staff #22. During the interview Staff #22 stated that Resident #40 would benefit from hand splints and the rehab department utilizes the Minimum Data Set assessment to determine which residents should be screened for splint application. The surveyor noted that on Resident #40's quarterly MDS assessment dated [DATE] the upper extremity impairment was coded for yes for both sides. On the significant change assessment dated [DATE] and the quarterly MDS assessment dated [DATE] the upper extremity impairments were coded to indicate that Resident #40 had no upper extremity impairments. On 11/13/24 at 11:19 AM, the surveyor conducted a phone interview with the Clinical Director of Reimbursement Staff #21. During the interview Staff #21 confirmed that the MDS assessments dated 6/28/24 and 9/28/24 were inaccurately coded for Resident #40's upper-extremity abilities. Cross reference F688

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50385 Based on record review and staff interview, it was determined that the facility failed to implement interventions in a care plan. This was evident for 1 (Resident #224) of 13 residents reviewed for care plans. The findings include: On 11/4/24 at 9:10 AM, a review of Facility Reported Incident #MD00203620 was conducted. The report stated that on 3/14/24 at 6:00 PM, Resident #224 pushed Resident #53 causing them to fall. On 11/4/24 at 10:29 AM, a review of the facility's investigation was conducted. The facility conducted an interview with Resident #224 and the resident confirmed they pushed the linen cart knocking Resident #53 to the floor because Resident #53 was trying to wander into Resident #224's room. Resident #224 stated in the interview that they told staff to keep the wandering residents out of his/her room or he/she would hurt them. On 11/4/24 at 11:23 AM, a review of Resident #53 care plans was conducted. A care plan for wandering was created after the incident on 3/14/24. On 11/4/24 at 11:45 AM, a review of Resident #224's care plans. The care plan initiated on 7/12/23 stated [Resident #224] has a behavior problem (conflict with other residents & staff, potential for physical and/or verbal aggression) r/t threats made to harm a neighboring resident on unit. The intervention for this care plan is documented as the resident's triggers for verbal aggression are invasion of privacy by residents wandering into [his/her] room. The resident's behavior is de-escalated by removing other residents from [his/her] room and minimizing wandering into [his/her] room through increased supervision.

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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** 45733 Based on interview and record review it was determined that the facility staff failed to ensure a resident's right to participate in the resident-centered care plan meeting and failed to conduct care plan meetings after each resident Minimum Data Set (MDS) assessment. This was found evident in 2 (Resident #147 & #51) out of 13 Residents reviewed for care planning. The findings include: 1) During a floor rounding, on 10/31/24 at 10:47 AM, Resident #147 stated, I don't remember I had a care-plan meeting. And I can be in the meeting. Resident #147 was admitted to the facility on [DATE] with diagnoses of dementia, dysphagia and abnormal gait. This resident's speech was logical, clear and he/she was able to make his/her needs known. Record review, on 10/31/24 at 2:17 PM, of Director of Social Service Staff #6's documentation revealed that the care-plan meeting was held by the care team on 10/21/24 attempted telephonically with this resident's family (no mention about if the resident was invited). Although, after they were unable to reach the family, the meeting was conducted by Staff #6 and the care team made care-plan decisions. Previous care-plan meetings on 7/30/24 and 4/29/24 were also conducted without the family nor the resident involved making decisions about his or her care. During the interview, on 10/31/24 at 3:26 PM, Staff #6 stated that she could not answer why the resident was not invited because she left it up to the family to decide. In fact, she never talked to the resident about his/her care-plan meeting. Staff #6 was informed that the care plan meeting practice was not resident centered and conducting an ineffective meeting pattern which were concerns. Further interviews, on 10/31/24 at 3:53 PM, reviewing the Social Work Services Staff's notes with DON and the Administrator concluded that the resident was excluded from his/her care plan meeting, which was a concern. Additionally, both agreed that it was a concern when a care-plan meeting did not get rescheduled after a resident or representative was unable to attend. 44440 2) On 11/7/24 at 8:47 AM, the surveyor reviewed Resident #51's medical record. The review revealed that Resident #51 had a quarterly Minimum Data Set (MDS) assessment completed on 7/13/24 and 10/24/24. On further review it was noted that a care plan meeting was held on 7/17/24, however, there was no care plan meeting documentation for the care plan to follow the 10/24/24 MDS assessment. On 11/7/24 at 12:12 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated that Resident #51 should have had a care plan meeting following her October MDS assessment and would look for documentation. At the time of the exit no documentation was provided that the care plan was held or scheduled.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 44440 Based on interviews and record review it was determined that the facility failed to have an activities program designed to meet the interests and needs of Residents based on the Residents comprehensive assessment and care plan. This was found evident of 1 (Resident #40) of 4 residents reviewed for activity during an annual survey. The findings include: On 10/29/24 at 11:49 AM, the surveyor interviewed Resident #40's family member. During the interview the family member reported that music was such a big part of Resident #40's life and that he/she used to play the guitar. The family member further stated that they had even brought in a music player to his/her room that would play Resident #40's favorite music. On 11/1/24 at 1:50 PM, the surveyor reviewed Resident #40's medical record. The review revealed a progress note dated 8/18/23 that stated a care plan meeting was held with Resident #40's family members in attendance. It further stated that the family was requesting Resident #40 be seen by a music recreational therapist if possible. A previous care plan note written on 6/2/23 reported Resident #40 received visits from staff that offer light hand message for relaxation, sound stimulation with familiar music and lights on for stimulation. Next the surveyor reviewed Resident #40's care plan and discovered a care plan that stated, Resident #40 is dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits and physical limitations. One of the interventions listed was to provide residents with music engagement. On 11/6/24 at 2:09 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked the DON for the activity assessments and activities that were offered and provided to Resident #40. On 11/7/24 at 7:38 AM, the surveyor conducted an interview with the Therapeutic Recreational Manager Staff #10. Staff #10 stated that when a resident is admitted a leisure inventory and history assessment is completed to help develop a plan care and that care plan is updated quarterly. She further stated that currently oversaw Resident #40's activities at this time. Staff #10 clarified that Resident #40 did not qualify to be seen by a Recreational Music Therapist but could be provided with music. The surveyor requested any activities that were provided to Resident #40 along with assessments. The surveyor reviewed the therapeutic recreational re-assessment completed on 6/26/24. Music listening was not checked as an activity in which the resident has participated in since the last review. However, the therapeutic recreational re-assessment completed on 10/7/24 did have music listening checked. The surveyor reviewed Resident #40's activity log for 1:1 sensory stimulation visits. There were 3 documented activities in August, 3 in September, 5 in October, and as of November 7th no activities were documented in November. On average Resident #40 was offered an activity less than weekly even when his/her care plan stated he/she was dependent on staff to meet this need.

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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. 44440 Based on observations, interviews, and record review, it was determined that the facility failed to provide treatments according to a Resident's plan of care. This was found evident of 1 (Resident #77) out of 2 residents reviewed for skin care. The findings include: On 10/29/24 at 9:24 AM, the surveyor conducted an interview with Resident #77 who stated that he/she had swelling in both lower legs. On 11/12/24 at 8:14 AM, the surveyor reviewed Resident #77's medical record. The review revealed a progress note written on 4/2/24 by Physician #20 after a follow-up visit. The note stated that Resident #77 reported that he/she spoke to the Nurse Practitioner about his/her feet swelling. The NP recommended compression socks. The note stated Resident #77 agreed to treatment and that Thrombo-Embolic Deterrent (TED) hose (hose or stockings that are applied to the lower legs and are designed to prevent blood clots and swelling in the legs) would be ordered. An order was then placed on 4/2/24 for TEDs to be applied during the day and taken off at night. The surveyor was not able to find any documentation in Resident #77's medical record that documented the TEDs were applied as ordered. On 11/12/24 at 10:40 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA confirmed that the order for TEDs did not translate to the Treatment Administration Record (TAR) and therefore was not able to provide documentation that the treatment was provided to Resident #77. On 11/12/24 at 12:55 PM, the surveyor observed Resident #77 in bed. Bilateral feet appeared to be swollen and no TEDs stocking were on. The surveyor asked Resident #77 if the TED stocking were on today. Resident #77 reported that the TEDs had not been on for weeks.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 44440 Based on record review and interviews it was determined that the facility failed to ensure a Resident in need of hearing aides received services to obtain replacement hearing aides. This was found evident of 1 (Resident #105) of 2 residents reviewed for hearing and vision. The findings include: On 11/1/24 at 9:56 AM, the surveyor reviewed Resident #105 ' s medical record. The review revealed that Resident #105 had a care plan that stated, Resident #105 has a communication problem related to hearing deficit in both ears as evidence by the use of hearing aids. The care plan further documented that Resident #105 had misplaced his/her hearing aids on 10/29/23. The hearing aid care plan updated on 12/29/23 stated that Resident #105 ' s brother would order another set of hearing aids with insurance coverage. The surveyor next reviewed October 2024 Treatment Administration Order (TAR). The treatment order stated, please check right and left ear hearing aids and assist resident and to apply hearing aids every shift. Every day there was a slot for the day time documentation for application and night time documentation for removal. 13 out to the 62 times a note was written that stated, Resident #105's hearing aids were missing. The other boxes were checked as completed. On further review the surveyor noted a progress note dated 7/10/24 from Social Worker Assistant Staff #30, that stated a care plan meeting was held with Resident #105's brother. It further stated that nursing was able to follow up with Resident #105 ' s brother regarding Resident #105's missing hearing aids. On 10/9/24 Staff #30 wrote another progress note that documented a clinical update was provided by nursing and that social work planned to follow up with guest relations to inquire about a solution for Resident #105's hearing aids. On 11/12/24 at 9:19 AM, the surveyor conducted an interview with the Director of Nursing (DON) and the Director of Social Service Staff #6. During the interview the surveyor asked for clarification if Resident #105 had hearing aids or if they were missing. Staff #6 stated she would find out when Resident #105's hearing aids went missing but believed that Staff #30 was working with Resident #105's brother to obtain new hearing aids. On 11/12/24 at 10:10 AM, the surveyor conducted a follow-up interview with Staff #6. During the interview Staff #6 confirmed that the hearing aids went missing on June 15th 2024. She further stated that after talking to Resident #105's brother, he does not want to pay for replacement hearing aids and that guest services would then need the information to go forward with replacing them. The surveyor relayed the concern that for over three months Resident #105 was without his/her hearing aids.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on observation, record review, and interviews it was determined that the facility failed to provide treatment to prevent further decreased range of motion for a Resident. This was found evident of 1 (Resident #40) out of 5 residents reviewed for mobility. The findings include: On 10/29/24 at 12:05 PM, the surveyor observed splints off in the corner of Resident #40's room. The surveyor asked Resident #40's family member if the splints were supposed to be on or off and the family member stated he/she was unclear at this time how they were to be used and that Resident #40 had contracted hands. On 11/12/24 at 1:07 PM, the surveyor interviewed Registered Nurse (RN) #27 in Resident #40's room. During the interview the surveyor asked RN #27 if Resident #40 was supposed to be wearing splints. RN #27 stated that Resident #40 was being trialed for tolerance of the splints by therapy before he/she went out to the hospital. She further stated that once a resident tolerates 8 hours in the splints, therapy gives nursing the splinting schedule and the nurses are to provide the cares. RN #27 was not aware of a splinting schedule for Resident #40 and stated that therapy usually puts the schedule on the wall when it becomes the nursing staff's responsibility to manage the splints. On 11/13/24 at approximately 8:30 AM, the surveyor reviewed Resident #40's Occupational Therapy (OT) notes. A note written on 7/22/24 documented Resident #40 tolerated passive range of motion to bilateral shoulder, elbows, wrists, hands/digits to maintain range of motion. It further stated Resident #40 was able to tolerate 3.5 hours of resting hand splints to the right hand but not able to for the left hand due to an intravenous line in Resident #40's hand. On 11/13/24 at 9:45 AM, the surveyor conducted an interview with the Rehab Manager Occupational Therapist (OT) Staff #22. During the interview Staff #22 stated that Residents who leave and return to the facility after a hospital stay are screened for splinting needs quarterly and that the department works with the Minimum Data Set (MDS) assessment department to help establish needs. Staff #22 further stated residents that require splints are started on a light schedule and are built up to tolerate 6-8 hours. The surveyor asked Staff #22 if Resident #40 was screened and triggered to be seen after returning to the facility from the hospital and from having a MDS assessment dated [DATE]. Staff #22 confirmed Resident #40 was not currently on the schedule but would benefit from splints. He further stated that splinting would start today. Cross reference F641

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44440 Based on review of medical records and interviews it was determined that the facility failed to adequately supervise and assist a dependent resident during Activity of Daily Living (ADL) care. This was found evident for 1 (Resident #121) out of 9 residents reviewed for accidents. The findings include: On 11/6/24 at 9:26 AM, the surveyor reviewed Resident #121 ' s medical record. The review revealed that a progress note written on 10/22/24, by Nurse Practitioner (NP) #39 that documented Resident #121 sustained a fall after attempting to transfer him/herself to the bedside commode. The note stated that the Geriatric Nursing Assistant (GNA) helped Resident #121's to the edge of the bed and stand up however left the room before Resident #121 transferred to the commode. Further review revealed Resident #121 had a care plan that was initiated on 10/21/24 that stated Resident #121 has a self-care deficit related to impaired mobility. One of the interventions listed was for Resident #121 to have assistance with toileting. On 11/6/24 at 11:59 AM, the surveyor interviewed the Director of Nursing (DON). In the interview the DON confirmed that the GNA assisting Resident #121 did not follow protocol and that Resident #121 should not have been left alone.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on observation, record review and interview it was determined that the facility staff failed to follow appropriate tube feeding treatment and gastrostomy tube (G-tube) site care. This was evident for 1 (Resident #36) out of 2 residents reviewed for tube feeding treatment during the annual survey. The findings include: Gastrostomy tube refers to a medical device which is placed directly into the resident's stomach, used to provide liquid nourishment, fluids, and medications by bypassing oral intake. Observation, on 10/31/24 at 9:26 AM, revealed that Resident #36's feeding pump was turned off but the feeding tubing was connected to the resident's G-tube. No label was on the formula bottle and the feeding tubing was not dated. Observation, on 11/7/24 at 10:15 AM, found that Resident #36's feeding formula bottle with tube feeding was hanging on a pole but not running and the feeding tube was connected to the Resident's G-tube again. No date was on the feeding tubing nor was the feeding formula bottle properly labeled. Record review, on 11/07/24 at 11:22 AM, found that Resident #36 was admitted to the facility on [DATE] with diagnoses of hemiplegia after a stroke, dysphagia and dementia. The last tube feeding order: Keep nothing by mouth, Nepro formula for 20 hours feeding time; off at 8 AM and on at 12 Noon daily. The G-tube site dressing order: Two times a day for infection prevention clean with normal saline, apply sponge gauze. Nepro is therapeutic nutrition specifically designed to help meet nutritional needs. For tube feeding supplemental or sole-source nutrition. Use under medical supervision. Observation and interview, on 11/08/24 at 1:30 PM, the surveyor went with the Nurse Manager Staff #8 to this resident's bedside and discovered that the feeding tube was not dated and the Nepro bottle was not properly labeled which did not follow the facility's tube feeding treatment policy. The G-tune site dressing was dated with the day before 11/7 with oozing drainage on the gauze. Additionally, on 10/31/24 & 11/7/24 after 8 AM, the tube feeding pump was observed turned-off but the feeding tube was still connected to the resident and pulled on the Resident's G-tube site. Per physician's orders the tube feeding stopped at 8 AM so the tubing should be disconnected at that time and the G-tube site dressing should have been changed twice a day. The on duty Nurse Staff #18 failed to ensure that Nepro container was labeled, take down the feeding tubing at 8 AM and change the G-tube site dressing twice each day. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Labeling tube feeding containers ensured that the right resident receives the ordered product and that those providing care know what date and time the tube feeding was hung. The date and time were important pieces of information because hanging a tube feeding longer than the manufacturer's recommendations can lead to contamination which could potentially affect residents. Furthermore, Staff #8 and the Director of Nursing were informed that all the above findings were deficient practice concerns.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 44440 Based on observation, record review, and interview with facility staff, it was determined that the facility failed to obtain a bed rail assessments and documentation that informed consent was obtained prior to the use of the bed rails. This was evident of 1 (Resident #141) residents reviewed for accidents. The findings include: Bed rails also known as side rails are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them, such as suffocation, entrapment, and psychological risks. A Resident or Resident Representative should be provided with the risks and benefits along with a signed consent obtained before the use of bedrails. On 10/29/24 at 11:26 AM, the surveyor observed Resident #141 turned and facing the left side of the bed. All 4 bed rails were noted up and Resident #141 was grabbing the bed rail. On 11/6/24 at 9:09 AM, the surveyor reviewed Resident #141 ' s medical record. The review revealed Resident #141 had a past medical history that included, but not limited to, hemiplegia (partial or complete paralysis on one side of the body) affecting left side and muscle weakness. On further review Resident #141 had a care plan initiated on 2/8/24 that stated Resident #141 was hemiplegia/hemiparesis related to a stroke. One of the interventions listed was to discuss any concerns, fears, issues regarding diagnoses or treatments with the resident/resident family. The surveyor was unable to find a bed rail evaluation or consent for bed rail use in Resident #141's medical record. On 11/6/24 at 1:03 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA stated that he was unable to find a bed rail assessment for Resident #141and further stated that Resident #141 was in a specialty bed that rotated, and that the bedrails needed to be up in order for the bed to work correctly. On 11/6/24 at 1:03 PM, the surveyor conducted a follow-up interview with the NHA and the Director of Nursing (DON). The surveyor asked if the beds were inspected and/or an assessment done to evaluate the risk for entrapment. The NHA stated the facility shared the clinical engineering with the hospital on campus and would reach out for clarifications. (continued on next page)

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Levindale Hebrew Ger Ctr & Hsp	2434 West Belvedere Avenue Baltimore, MD 21215

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 9:34 AM, the surveyor conducted a phone interview with the Corporate Director of Clinical Operations Staff #31. During the interview Staff #31 stated his department is only involved in servicing the specialty beds when they are not working correctly and do not evaluate for entrapment. He further stated any manufacture manual for a bed will give the warning there is a risk of the possibility of entrapment. He further stated he refers to the instruction for use manual for guidance. On 11/7/24 at 11:11 AM, the surveyor reviewed the Specialty Bed Instruction for Use manual. In the section labeled Siderails there is a statement that stated; The use of siderails in the bed position should be determined according to patient need after assessing any risk factors according to the facility protocols for safe positioning. A warning stated; Evaluate patient for entrapment risk according to facility protocol, and monitor patient appropriately. Make sure that all siderails are fully latched when in the raised position. Failure to do either of these could cause serious injury or death. A side note stated; Siderails are intended to be a reminder, not a patient restraining device. The manufacturer recommends that the appropriate medical personnel determine appropriate siderail usage. After review of the user manual the surveyor relayed the concerns there was no evaluation or consent for use of bedrails in Resident #141's medical record.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 44440 Based on observations, reviews, and interviews it was determined that the facility failed to provide necessary behavioral health services according to the identified individual need in the plan of care. This was found evident of 3 (Resident #105, #245 & #214) 3 residents reviewed for behavioral health services. The findings include: 1a) On 10/29/24 at 1:07 PM, the surveyor observed Resident #105 clapping and speaking to things/people that were not in the room. On 10/31/24 at 2:06 PM the surveyor reviewed Resident #105's medical record. The review revealed that Resident #105 had a care plan for altered thought processes related to dementia, hallucinations and psychosis as well as inappropriate/disruptive behavior related to hallucinations and psychophysical visual disturbances. Additionally, Resident #105 had a care plan for mood disturbances related to dementia and major depressive disorder. Listed interventions for this care plan were to administer medications as ordered and behavior health consults as needed. Review of the progress notes revealed a note written on, 4/19/24 by Licensed Practical Nurse (LPN) Staff #25, that described Resident #105 was speaking to him/herself and asking staff to leave the room. The note then describes Resident #105 had thrown his/her beverage across the floor and continued to have an intense conversation while talking to him/herself when no one was present in the room. Another nursing note written, by LPN Staff #26 on 5/1/24, documented Resident #105 was getting louder and more agitated. The note described that Resident #105 was using foul language and having hallucinations screaming at whoever he/she believes was in the room with him/her. The surveyor next reviewed a note written by Nurse Practitioner (NP) Staff #24 on 6/5/24, that stated Resident #105 had chronic hallucinations and was being followed closely by psychiatry/psychology (psych) services. On further review psych wrote progress notes on 7/11/23, 8/14/23, 8/25/23, 1/5/24, 10/4/23 and 10/7/24. On 11/1/24 at 2:25 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that there were only three psych visits from 2024. Two from the previous psych provider and one from the new provider Nurse Practitioner (NP) Staff #15. The surveyor reviewed the concern that no psych services were documented from January 5th 2024 to October 4th 2024 even though it was documented that psych services were closely monitoring. 1b) On 10/29/24 at 9:44 AM, the surveyor observed Resident #245 restless in bed and pulling at his/her Gastrostomy (a surgically inserted into the stomach through the abdominal wall). (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 11:47 AM, the surveyor reviewed Resident #245's medical record the review revealed a note written by Registered Nurse (RN) Staff #27 that stated Resident #245 disconnected him/herself from the ventilator (machine that helps a person breathe) pulling at tubes and wrapping tubing around the neck. The note further states that Resident #245 appears to be anxious. On further review an order was written on 11/4/24 for Resident #245 to have psych consultation (consult) related to agitation. On 11/8/24 at 10:15 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). The NHA confirmed that the consultation had not happened yet and the expectation was that when the provider comes into the building the consultation would be completed. On 11/8/24 at 10:45 AM, the surveyor conducted a phone interview with NP Staff #15 along with the NHA. During the interview Staff #15 stated she is alerted to a new consult either by fax or when she is in the facility she is told by staff. Staff #15 further stated she is in the facility 3-4 days per week and was last at the facility on Monday. When asked if she was aware of any new consults Staff #15 stated she was not aware of any new consults this week and would have seen them if she was aware. She stated she was just told about the consult for Resident #245 today and planned on seeing him/her tomorrow. After the call ended, the surveyor reviewed the concern with the NHA that the psych consult was delayed and the provider would have performed the consultation this week if the order had been relayed. 1c) On 11/18/24 at 7:41 AM, the surveyor reviewed Resident #214's medical record. The review revealed a progress note written on 5/17/24 by Licensed Practical Nurse (LPN) Staff #28. The note stated that Resident #214 reported being short of breath and was observed holding a pillow tight rocking back and forth. It further described Resident #214 was screaming for his/her sister. In the note Staff #28 stated that an as needed Seroquel (an antipsychotic medication given to treat several kinds of mental health conditions) was given and effective. On further review, a progress note written by Physician, Staff #29 on 5/17/24 wrote, Resident #214 is requiring multiple antipsychotic mediation regimens and having behaviors off and on. Staff #29 then wrote, Psych consulted. The surveyor next reviewed orders for Resident #214. An order for a psych consult was written on 5/26/24. This was 9 days after Staff #28 identified the need for a psych consult. On 11/18/24 at 8:21 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern that there was a delay in ordering psych services after the need was identified by the provider.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50385 Based on record review and staff interview, it can be determined that the provider failed to follow through with a pharmacist's recommendation after a medication regimen review. This was evident for 1 (Resident #92) of 5 resident's reviewed for unnecessary medications. The findings include: On 11/06/24 at 11:45 AM, a review of Resident #92's medication regimen reviews was conducted. In the pharmacy medication review conducted on 10/19/24, the pharmacist requested Novolog to be discontinued and to have the resident's A1C checked. Provider agreed to this recommendation and signed and dated the signature 11/11/24 per the documentation provided. On 11/06/24 at 12:00 PM, Resident #92's orders were reviewed. Novolog was shown as an active order and there was no order for an A1C lab since the medication regimen review. On 11/06/24 at 12:06 PM, an interview was conducted with the Director of Nursing (Staff #2). When asked what the expectation was for the providers to place orders on recommendations from the pharmacist that the provider agrees with, Staff #2 stated that if the provider agrees with a recommendation, they should write the order at the time of signing the recommendation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on interviews and record review it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices. This was found evident in 3 (Resident #140, #33 and #72) out of 73 residents reviewed during the survey. The findings include: 1a) On [DATE] at 7:23 AM, the surveyor reviewed Resident #140's medical record. The review revealed that Resident #140 had two bed rotation orders. The first order was written on [DATE] and stated, Rotation via bed, when on back, 50% turn to right 50% turn to left, turn for 5 minutes. The second order was written on [DATE] and stated, Total care low air loss bed with rotation, 40% right turn, 40% left turn, 0.5 minute pause. The surveyor reviewed the November Treatment Administration Record (TAR). The review revealed that both orders were checked as completed [DATE]-[DATE]. On [DATE] at 9 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated that when an order is changed the physician should go through and update and/or discontinue orders that are not needed. The DON was not sure why the two different orders were written for bed rotation and stated she would follow-up after looking into the concern. On [DATE] at 12:25 PM, the surveyor conducted a follow-up interview with the DON. During the interview the DON explained that the first bed rotation order was put in as a standard order. The following bed order was placed by the treatment team. She further stated that having the two different orders in Resident #140's record was an error. 50385 1b) On [DATE] at 1:38 PM, a review of Resident #33 and #72 electronic and paper records was conducted. The code status in the paper charts for both residents was No CPR. The code status in the electronic charts for both residents stated, Full Code See MOLST [Maryland Orders for Life Sustaining Treatment], MOLST form on file. On [DATE] at 1:45 PM, an interview was conducted with the Nurse Manager (Staff #8). When asked what the expectation for nursing staff to check for code status is, Staff #8 stated the nurses are to check the most up to date MOLST in the paper chart. This surveyor notified Staff #8 of discrepancy in Resident #33 and #72's code statuses. Staff #8 corrected the code status orders in electronic chart after surveyor intervention. On [DATE] at 2:05 PM, an interview was conducted with Staff #14. When asked where nursing staff is expected to check for a resident's code status, Staff #14 stated they would use the most up to date MOLST in the paper chart as determinant of the resident's code status. When asked if the code statuses in the paper and electronic chart do not match which one would they use, Staff #14 stated they would check the dates of both orders and use the most up to date.