

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215013	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
NAME OF PROVIDER OR SUPPLIER St. Mary's Nursing Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 21585 Peabody Street Leonardtown, MD 20650	

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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>42886</p> <p>Based on medical record review and interview, the facility failed provide adequate notice to a resident (resident #1) prior to discharge. This was evident in 1 of 5 residents reviewed during a complaint survey.</p> <p>Findings include:</p> <p>Review of resident #1's medical records on 7/25/24 at 9:30am revealed that on 7/17/24, the resident was transferred from the facility for emergency treatment after the resident's family observed that the resident moved slower than usual. Further review of resident #1's medical records on 7/25/24 at 10:00 am revealed that on 7/18/24, the resident was admitted to the local hospital for observation for sepsis (systemic infection) caused by a urinary tract infection. Continued review of resident #1's medical records on 7/25/24 at 11:00am revealed no evidence of the facility providing the resident/resident representative with notice prior to discharge from the facility.</p> <p>Interview with the complainant/resident #1's power of attorney (POA) on 7/25/24 at 11:30am revealed that on 7/18/24, the complainant/POA requested a care conference to discuss the care of the resident after discharge from the local hospital. On 7/19/24 at 10:30am, the complainant/POA attended the requested care conference with the Administrator, Director of Nursing (DON), and Social Worker #2 in attendance. The complainant/POA stated that he/she requested additional interventions to the resident's care plan. The Administrator told the complainant/POA that the facility would consider the changes to resident#1's care plan. Later in the day on 7/19/24, the facility called the complainant/POA and informed the complainant that the facility could no longer meet the family's care expectations so the facility would not allow the resident to return to the facility after discharge from the local hospital. The complainant/POA stated that prior to the call from facility, the resident's family received no notice or indication that the facility would not allow the resident to return to the facility after hospital treatment. The complainant/POA also revealed that the facility's failure to allow the resident to return causes psychosocial harm to the resident because the facility has the staff and environment that best meets the needs of the resident.</p> <p>(continued on next page)</p>

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Administrator and the DON on 7/25/24 at 12:30pm confirmed that the facility refused to allow the resident to return to the facility after discharge from the local hospital. The Administrator stated that the family had unrealistic expectations for the resident's care. The Administrator also confirmed the 7/19/24 care conference with the complainant/POA. During the 7/19/24 care conference meeting, the complainant/POA gave the family's care expectations after the resident returned from the hospital. The Administrator stated that he/she told the complainant/POA that the facility would consider the changes to the care plan. The Administrator further stated that he/she later decided to refuse the resident's return to the facility after discharge from the hospital. The DON provided additional information on the history of the interactions with the complainant/POA and the facility. The DON stated that the complainant/POA would change expectations for the resident's care and expect the change to occur immediately for all staff persons. The DON also stated that the complainant/POA would visit frequently and criticize observed care given to the resident. The Administrator stated, I refuse to let the resident back here. I don't care. I will take the tag. We can provide the care for the resident but not at the expectation of the . (complainant/POA).</p> <p>The surveyor expressed concern to the Administrator and the DON that the facility failed to provide adequate notice to resident #1 or the resident representative prior to discharge. The Administrator and the DON understood.</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>42886</p> <p>Based on medical record review and interview, the facility failed prepare a resident (resident #1) for discharge. This was evident in 1 of 5 residents reviewed during a complaint survey.</p> <p>Findings include:</p> <p>Review of resident #1's medical records on 7/25/24 at 9:30am revealed that on 7/17/24, the resident was transferred from the facility for emergency treatment after the resident's family observed that the resident moved slower than usual. Further review of resident #1's medical records on 7/25/24 at 10:00 am revealed that on 7/18/24, the resident was admitted to the local hospital for observation for sepsis (systemic infection) caused by a urinary tract infection. Continued review of resident #1's medical records on 7/25/24 at 11:00am revealed no evidence of the facility providing the resident/resident representative with notice prior to discharge from the facility.</p> <p>Interview with the complainant/resident #1's power of attorney (POA) on 7/25/24 at 11:30am revealed that on 7/18/24, the complainant/POA requested a care conference to discuss the care of the resident after discharge from the local hospital. On 7/19/24 at 10:30am, the complainant/POA attended the requested care conference with the Administrator, Director of Nursing (DON), and Social Worker #2 in attendance. The complainant/POA stated that he/she requested additional interventions to the resident's care plan. The Administrator told the complainant/POA that the facility would consider the changes to resident#1's care plan. Later in the day on 7/19/24, the facility called the complainant/POA and informed the complainant that the facility could no longer meet the family's care expectations so the facility would not allow the resident to return to the facility after discharge from the local hospital. The complainant/POA stated that prior to the call from facility, the resident's family received no notice or indication that the facility would not allow the resident to return to the facility after hospital treatment. The complainant/POA also revealed that the facility's failure to allow the resident to return causes psychosocial harm to the resident because the facility has the staff and environment that best meets the needs of the resident.</p> <p>Interview with the Administrator and the DON on 7/25/24 at 12:30pm confirmed that the facility refused to allow the resident to return to the facility after discharge from the local hospital. The Administrator stated that the family had unrealistic expectations for the resident's care. The Administrator also confirmed the 7/19/24 care conference with the complainant/POA. During the 7/19/24 care conference meeting, the complainant/POA gave the family's care expectations after the resident returned from the hospital. The Administrator stated that he/she told the complainant/POA that the facility would consider the changes to the care plan. The Administrator further stated that he/she later decided to refuse the resident's return to the facility after discharge from the hospital. The DON provided additional information on the history of the interactions with the complainant/POA and the facility. The DON stated that the complainant/POA would change expectations for the resident's care and expect the change to occur immediately for all staff persons. The DON also stated that the complainant/POA would visit frequently and criticize observed care given to the resident. The Administrator stated, I refuse to let the resident back here. I don't care. I will take the tag. We can provide the care for the resident but not at the expectation of the . (complainant/POA).</p> <p>(continued on next page)</p>		

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor expressed concern to the Administrator and the DON that the facility failed to prepare resident #1 or the resident representative prior to discharge. The Administrator and the DON understood.		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>42886</p> <p>Based on medical record review and interview, the facility failed to allow a resident (resident #1) to return to the facility after transfer for emergency treatment. This was evident in 1 of 5 residents reviewed during a complaint survey.</p> <p>Findings include:</p> <p>Review of resident #1's medical records on 7/25/24 at 9:30am revealed that on 7/17/24, the resident was transferred from the facility for emergency treatment after the resident's family observed that the resident moved slower than usual. Further review of resident #1's medical records on 7/25/24 at 10:00 am revealed that on 7/18/24, the resident was admitted to the local hospital for observation for sepsis (systemic infection) caused by a urinary tract infection. Continued review of resident #1's medical records on 7/25/24 at 11:00am revealed no evidence of the facility providing the resident/resident representative with notice prior to discharge from the facility.</p> <p>Interview with the complainant/resident #1's power of attorney (POA) on 7/25/24 at 11:30am revealed that on 7/18/24, the complainant/POA requested a care conference to discuss the care of the resident after discharge from the local hospital. On 7/19/24 at 10:30am, the complainant/POA attended the requested care conference with the Administrator, Director of Nursing (DON), and Social Worker #2 in attendance. The complainant/POA stated that he/she requested additional interventions to the resident's care plan. The Administrator told the complainant/POA that the facility would consider the changes to resident#1's care plan. Later in the day on 7/19/24, the facility called the complainant/POA and informed the complainant that the facility could no longer meet the family's care expectations so the facility would not allow the resident to return to the facility after discharge from the local hospital. The complainant/POA stated that prior to the call from facility, the resident's family received no notice or indication that the facility would not allow the resident to return to the facility after hospital treatment. The complainant/POA also revealed that the facility's failure to allow the resident to return causes psychosocial harm to the resident because the facility has the staff and environment that best meets the needs of the resident.</p> <p>Interview with the Administrator and the DON on 7/25/24 at 12:30pm confirmed that the facility refused to allow the resident to return to the facility after discharge from the local hospital. The Administrator stated that the family had unrealistic expectations for the resident's care. The Administrator also confirmed the 7/19/24 care conference with the complainant/POA. During the 7/19/24 care conference meeting, the complainant/POA gave the family's care expectations after the resident returned from the hospital. The Administrator stated that he/she told the complainant/POA that the facility would consider the changes to the care plan. The Administrator further stated that he/she later decided to refuse the resident's return to the facility after discharge from the hospital. The DON provided additional information on the history of the interactions with the complainant/POA and the facility. The DON stated that the complainant/POA would change expectations for the resident's care and expect the change to occur immediately for all staff persons. The DON also stated that the complainant/POA would visit frequently and criticize observed care given to the resident. The Administrator stated, I refuse to let the resident back here. I don't care. I will take the tag. We can provide the care for the resident but not at the expectation of the . (complainant/POA).</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>42886</p> <p>Based on medical record review and interview, the facility's administration failed to provide leadership to facility staff to ensure CMS regulations are being followed when involuntarily discharging a resident (resident #1). This was evident in 1 of 5 residents reviewed during a complaint survey.</p> <p>Findings include:</p> <p>Review of resident #1's medical records on 7/25/24 at 9:30am revealed that on 7/17/24, the resident was transferred from the facility for emergency treatment after the resident's family observed that the resident moved slower than usual. Further review of resident #1's medical records on 7/25/24 at 10:00 am revealed that on 7/18/24, the resident was admitted to the local hospital for observation for sepsis (systemic infection) caused by a urinary tract infection. Continued review of resident #1's medical records on 7/25/24 at 11:00am revealed no evidence of the facility providing the resident/resident representative with notice prior to discharge from the facility.</p> <p>Interview with the complainant/resident #1's power of attorney (POA) on 7/25/24 at 11:30am revealed that on 7/18/24, the complainant/POA requested a care conference to discuss the care of the resident after discharge from the local hospital. On 7/19/24 at 10:30am, the complainant/POA attended the requested care conference with the Administrator, Director of Nursing (DON), and Social Worker #2 in attendance. The complainant/POA stated that he/she requested additional interventions to the resident's care plan. The Administrator told the complainant/POA that the facility would consider the changes to resident#1's care plan. Later in the day on 7/19/24, the facility called the complainant/POA and informed the complainant that the facility could no longer meet the family's care expectations so the facility would not allow the resident to return to the facility after discharge from the local hospital. The complainant/POA stated that prior to the call from facility, the resident's family received no notice or indication that the facility would not allow the resident to return to the facility after hospital treatment. The complainant/POA also revealed that the facility's failure to allow the resident to return causes psychosocial harm to the resident because the facility has the staff and environment that best meets the needs of the resident.</p> <p>Interview with the Administrator and the DON on 7/25/24 at 12:30pm confirmed that the facility refused to allow the resident to return to the facility after discharge from the local hospital. The Administrator stated that the family had unrealistic expectations for the resident's care. The Administrator also confirmed the 7/19/24 care conference with the complainant/POA. During the 7/19/24 care conference meeting, the complainant/POA gave the family's care expectations after the resident returned from the hospital. The Administrator stated that he/she told the complainant/POA that the facility would consider the changes to the care plan. The Administrator further stated that he/she later decided to refuse the resident's return to the facility after discharge from the hospital. The DON provided additional information on the history of the interactions with the complainant/POA and the facility. The DON stated that the complainant/POA would change expectations for the resident's care and expect the change to occur immediately for all staff persons. The DON also stated that the complainant/POA would visit frequently and criticize observed care given to the resident. The Administrator stated, I refuse to let the resident back here. I don't care. I will take the tag. We can provide the care for the resident but not at the expectation of the . (complainant/POA).</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The surveyor expressed concern to the Administrator and the DON that the facility failed to provide leadership to facility staff when resident #1 was being involuntarily discharged . The Administrator and the DON understood.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42886</p> <p>Based on medical record review and interview, the facility failed to document the discharge of a resident (resident #1). This was evident in 1 of 5 residents reviewed during a complaint survey.</p> <p>Findings include:</p> <p>Review of resident #1's medical records on 7/25/24 at 9:30am revealed that on 7/17/24, the resident was transferred from the facility for emergency treatment after the resident's family observed that the resident moved slower than usual. Further review of resident #1's medical records on 7/25/24 at 10:00 am revealed that on 7/18/24, the resident was admitted to the local hospital for observation for sepsis (systemic infection) caused by a urinary tract infection.</p> <p>Continued review of resident #1's medical records on 7/25/24 at 11:00am revealed no document that the facility discharged the resident nor was there evidence that the facility provided the resident/resident representative with notice prior to discharge.</p> <p>Interview with the complainant/resident #1's power of attorney (POA) on 7/25/24 at 11:30am revealed that on 7/18/24, the complainant/POA requested a care conference to discuss the care of the resident after discharge from the local hospital. On 7/19/24 at 10:30am, the complainant/POA attended the requested care conference with the Administrator, Director of Nursing (DON), and Social Worker #2 in attendance. The complainant/POA stated that he/she requested additional interventions to the resident's care plan. The Administrator told the complainant/POA that the facility would consider the changes to resident#1's care plan. Later in the day on 7/19/24, the facility called the complainant/POA and informed the complainant that the facility could no longer meet the family's care expectations so the facility would not allow the</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>resident to return to the facility after discharge from the local hospital. The complainant/POA stated that prior to the call from facility, the resident's family received no notice or indication that the facility would not allow the resident to return to the facility after hospital treatment. The complainant/POA also revealed that the facility's failure to allow the resident to return causes psychosocial harm to the resident because the facility has the staff and environment that best meets the needs of the resident.</p> <p>Interview with the Administrator and the DON on 7/25/24 at 12:30pm confirmed that the facility refused to allow the resident to return to the facility after discharge from the local hospital. The Administrator stated that the family had unrealistic expectations for the resident's care. The Administrator also confirmed the 7/19/24 care conference with the complainant/POA. During the 7/19/24 care conference meeting, the complainant/POA gave the family's care expectations after the resident returned from the hospital. The Administrator stated that he/she told the complainant/POA that the facility would consider the changes to the care plan. The Administrator further stated that he/she later decided to refuse the resident's return to the facility after discharge from the hospital. The DON provided additional information on the history of the interactions with the complainant/POA and the facility. The DON stated that the complainant/POA would change expectations for the resident's care and expect the change to occur immediately for all staff persons. The DON also stated that the complainant/POA would visit frequently and criticize observed care given to the resident. The Administrator stated, I refuse to let the resident back here. I don't care. I will take the tag. We can provide the care for the resident but not at the expectation of the . (complainant/POA).</p> <p>The surveyor expressed concern to the Administrator and the DON that the facility failed to</p> <p>(continued on next page)</p>		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document the discharge of resident #1 on the resident ' s medical records. The Administrator and the DON understood.		