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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50385 Based on record review and staff interviews, it was determined that the facility failed to protect the residents' private space from unauthorized photographs and recordings. This was evident for 1 (Household 5) out of 10 units. The findings include: On 11/12/24 at 11:53 AM, a review of complaint #MD00194059 was conducted. The complaint stated that Staff #19 recorded themselves in a common care area and posted it on the social media platform Tiktok. On 11/13/2024 at 9:58 AM, Staff #19's employee file was reviewed. The employee file revealed that Staff #19 was terminated for Gross Misconduct. The specific incident causing termination was that the employee was caught recording a video of themselves in a clinical area and posted it on social media. In Staff #19's statement, they stated that she admitted to recording video in the care area while on break. Staff #19 stated that no residents were recorded. On 11/13/2024 at 10:30 AM, an interview with the Director of Nursing (DON) was conducted. When asked if Staff #19 was educated on resident rights and Health Insurance Portability and Accountability Act HIPAA (a federal law that protects the security and confidentiality of personal health information), the DON stated that they were educated on orientation. The DON provided this surveyor with proof of the education provided to Staff #19. On 11/13/24 at 1:26 PM, an interview was conducted with the Administrator (Staff #1). Staff #1 stated that the incident was reported to administration anonymously and was reported to have happened on Household 5. Staff #1 stated that no specific resident was involved but Staff #19 did record a video on Household #5 and posted it on social media.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44440 Based on observation, review of the facility's investigation report, record review, and interviews, it was determined that the facility failed to protect a resident from physical and verbal abuse. This was found evident of 2 (Resident #201 & #53) of 7 Residents reviewed for abuse. The findings include: 1a) On 11/15/25 at 8:53 AM, the surveyor reviewed Resident #201's medical record. The review revealed that Resident #201 was readmitted to the facility related to multiple falls. Further review revealed a progress note written by Physician #34 on 11/30/24 that reported Resident #201 was very confused at baseline and due to impaired gait and high fall risk a 1:1 (one resident to one staff person care services) sitter was ordered. The surveyor reviewed a summary for provider note written by Registered Nurse (RN)# 35 dated 12/26/23. RN #35 described in the note that she heard the 1:1 sitter shouting out from Resident #201's room. When she entered the room Resident #201 was lying in the bed with his legs hanging out of bed. She further reported she did not know what happened in the room before she entered. On 11/15/24 at 9:10 AM, the surveyor reviewed the facility's investigation file into the alleged abuse reported by Resident #201 from Certified Nursing Assistant (CNA)#32. The file contained a statement from Resident #201 and alleged CNA #32 provided rough care, hit him/her with a flashlight, and kept yelling at him/her. The surveyor reviewed the statement from Resident #201's roommate Resident #46. Resident #46 witnessed CNA #32 be rough with Resident #201 and reported CNA #32 was grabbing him/her by the wrists, ankles and feet. Resident #46 also stated CNA #32 was slamming Resident #201 into the wheelchair and when Resident #201 stated ouch your hurting me CNA #32 did not stop. There was, however, no corroboration that Resident #201 was hit by CNA #32 with a flashlight. On 11/18/24 at 9:13 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated the CNA#32 was suspended and later terminated related to the incident. She further stated that it was determined that CNA#32 had poor customer service. The DON agreed that CNA #32 was verbally abusive to Resident #201 and should not have been yelling at the resident. On 11/18/24 at 9:13 AM, the surveyor interviewed Resident #46, Resident #201's roommate at the time of the incident. During the interview Resident #46 confirmed his/her statement that rough care was witnessed, and that CNA #32 was rough with Resident #201. He/she stated that he/she remembered the day of the incident because he/she had been woken up in the early hours of the morning from CNA #32 yelling at Resident #201. Resident #46 further stated he/she felt scared in that moment due to the yelling. 50385 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1b) On 10/29/24 at 9:45 AM, an observation of Resident #53 was made. The resident was observed lying in bed and was noted to have a hearing impairment. Upon further review of the resident's record, the resident was noted to have a Brief Interview for Mental Status (BIMS) score of 6. The Brief Interview for Mental Status (BIMS) is a structured evaluation aimed at evaluating aspects of cognition in elderly patients. BIMS score: Interpretation, 0 - 7: Severe cognitive impact, 8 - 12: Moderate impairment, 13 - 15: Intact cognitive response. 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 room or he 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 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49815 Based on facility staff interviews and closed record reviews it was determined that the facility failed to report alleged violations of abuse as required. This was found to be evident in 5 (Resident #11, #217, #195 & #39 & #147) out of 13 Residents reviewed for reporting of alleged violations. The findings include: 1a) On 11/4/2024 at 9:45 AM the surveyor reviewed the facility investigation file for the facility reported incident (FRI) #MD00200402 for Resident #11. Review of the facility investigation file revealed that Resident #11 sustained a fracture of the right hip, and the facility Director of Nursing (DON) reported the fracture as an injury of unknown origin on the initial report form that was submitted to the Office of Healthcare Quality (OHCQ) on 12/8/2023 at 14:30 PM (2:30 PM). Further review of the facility investigation file (FRI) and Resident #11's closed medical record on 11/4/2024 at 11:00 AM revealed that Resident #11 reported that he/she had a fall. A fall risk assessment tool, neurological assessments and change in condition progress note was documented by nursing staff for Resident #11 on 12/8/2023. In an interview with the Nursing Home Administrator (NHA) on 11/4/2024 at 11:30 AM, the surveyor conveyed to the NHA that the Office of Healthcare Quality (OHCQ) did not receive a final investigation/follow-up report form for this 12/8/2023 facility reported incident (FRI) from the facility. The NHA acknowledged the surveyor and was unable to provide the surveyor with a final/investigation follow-up report for this 12/8/2023 facility reported incident (FRI). The only report that the OHCQ received from the facility was the initial report form on 12/8/2023 at 14:30 PM, and the only report that the Nursing Home Administrator was able to provide was the initial report form for this 12/8/2023 facility reported incident (FRI). 1b) On 11/15/2024 at 9:01 AM the surveyor reviewed complaint #MD00171165 that was received on 8/27/2021 at 15:55 PM (3:55 PM at the Office of Healthcare Quality (OHCQ) and Resident #217's closed medical record. Review of the medical record revealed that Registered Nurse (RN) #36 documented in the progress notes of Resident #217 at 7:43 AM on 8/27/2021 that Geriatric Nursing Assistant (GNA) stated by informed daughter on phone that Resident #217 was strangled by staff. Additionally, in the progress notes for Resident #217, there was a skin/wound note dated 8/27/2021 at 13:36 PM (1:36 PM), skin evaluation completed by treatment team, skin intact with no open areas, no rash, no lesions, bruise noted to right hand. In an interview with the Nursing Home Administrator (NHA) on 11/18/2024 at 8:00 AM, the surveyor conveyed to the NHA the progress note that was documented in Resident #217's medical record by RN #36 regarding an allegation of abuse. The surveyor asked the NHA for any concern or compliant forms for Resident #217. In a follow-up interview at 10:22 AM, the NHA stated that he did not have any concern or complaint forms for Resident #217 and he further stated that he would review his files to see if he had any facility reported incidents (FRI) for Resident #217. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Follow-up interview with the Nursing Home Administrator (NHA) at 11:52 AM on 11/18/2024, the NHA stated that he was not able to locate any facility reported incidents (FRI) for Resident #217, and that he was not notified of any allegation of abuse for Resident #217. Additionally, the NHA stated that he was not aware of the progress note and the allegation of abuse that was documented in Resident #217's closed medical record. The surveyor reviewed the employee personnel file for Registered Nurse (RN) #36 on 11/19/2024 at 9:15 AM. Review of the employee personnel file revealed that RN #36 received abuse training and abuse education which included reporting of allegations of abuse to facility management. RN #36 was no longer employed by the facility. No additional information was provided by the Nursing Home Administrator (NHA). 50385 1c) On 11/15/24 at 10:55 AM, Facility Reported Incident #MD00185819 was reviewed. The report stated that Resident #195 alleged abuse from a GNA. The allegation was that the GNA pulled the resident on to the floor on 11/17/2022 at 8:30 AM. The resident's representative reported this incident to staff 11/17/2022 at 9:30 AM. On 11/15/24 at 11:15 AM, The facility's report of the alleged abuse was reviewed. The documentation provided indicated that the initial and final report was sent to the Office of Health Care Quality on 11/18/2022 at 9:30 AM. On 11/15/24 at 11:20 AM, an interview was conducted with the Administrator. The Administrator confirmed that the initial and final report were sent together on 11/18/2022 at 9:30 AM. 45733 1d) Record review, on 11/14/24 at 2:20 PM, of the facility's self-report investigation file MD: 00206273, revealed that the medical record Nurse Staff #37 documented that Resident #39 had a change in condition of left knee pain and swelling on 6/2/24 at 5:58 PM. Further review found that the facility initial self-report to OHCQ was sent on 6/3/24 at 5:06 AM which was 9 hours later. The facility staff failed to report the allegation of abuse immediately but not later than 2 hours after the event. During the interview, on 11/14/24 at 3PM, the Director of Nursing (DON) was made aware of the concern related to the late reporting on 6/3/24 at 5:06 AM. The DON indicated that she did not handle this incident but understood that it was a concern that the initial report to OHCQ was outside of the 2 hours timeline. 1e) Record review, on 11/4/24 at 9:30 AM, of the facility's self-report investigation file MD: 00196122, revealed that Geriatric Nursing Assistant (GNA) Staff #38's interview statement that she reported to shift nurse, on 8/27/23 at 8:20 PM, of the Resident #147's multiple bruises to the right eye, right hand and bilateral lower extremities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This reasonable suspicion of abuse should have been reported immediately to OHCQ but not later than 2 hours from the time that the event was reported. However, the facility's initial report to OHCQ was not sent until 8/28/23 at 12:16 AM, almost 16 hours later. During interview, on 11/4/24 at 12:01 PM, the DON confirmed that the facility initial self-report was sent on 8/28/23 at 12:16 AM. The DON was informed that it was a concern.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 50385 Based on record review and staff interview, it was determined the facility failed to maintain pertinent documentation of a reported investigation. This was evident for 1 (Resident #197) of 24 facility reported incidents. The findings include: On 10/31/24 at 9:00 AM, an interview was conducted with Staff #1 and Staff #2. The staff members provided the surveyors with their investigations for all facility reported incidents. When asked if the documents provided were their complete investigations, they responded that they provided the surveyors with the complete investigation for each of the incidents that were reported. On 11/8/24 at 8:53 AM, a review of Facility Reported Incident #MD00189103 was conducted. On 2/6/23, Resident #197 was sent out for further evaluation related to fever, tachycardia, and hypotension. The facility identified that the nurse incorrectly entered the medications from the discharge summary on 2/8/2023. In the facility's report they stated, The current hospital course c/b AMS and hypotension initially requiring pressor support. Ongoing leukocytosis. Treated with empiric meropenem for possible sepsis, abx. Per hospital documentation, [Resident #197]'s AKI is the result of [his/her] Sepsis. On 11/8/24 at 1:30 PM, an interview was conducted with the Director of Nursing (Staff #2). When asked if they could provide the hospital records of resident's course at hospital after discharge from Levindale on 2/6/23, Staff #2 stated she cannot provide this because they would be breaking HIPAA if they were to ask for the records from the outside hospital. This surveyor was able to obtain records directly from the hospital.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 50385 Based on record review and staff interview, it was determined that the facility failed to adequately evaluate the effectiveness of pain medication for a resident. This was evident for 1 (Resident #22) out of 14 residents reviewed for pain management. The findings include: On 11/12/24 at 1:24 PM, a review of complaint #MD00194402 was conducted. The complainant stated that Resident #221 did not receive medications including tramadol as ordered. On 11/12/24 at 1:27 PM, Resident #22's orders were reviewed. Tramadol, an opiate and pain relief medication, oral tablet 50 MG was ordered to be given as 1 tablet by mouth every 6 hours as needed for moderate to severe pain. On 11/12/24 at 1:28 PM, a review of Resident #22's administration notes was conducted. A follow-up note on 7/12/2023 at 2:34 AM to the administration of Tramadol on 7/11/2023 at 6:59 PM, stated follow-up Pain Scale was 5 out of 10 and stated [As needed] Administration was: Ineffective. The effectiveness of the pain medication was evaluated 7 hours and 30 minutes after administration. A follow-up note on 7/11/2023 at 5:59 PM to the administration of Tramadol on 7/11/2023 at 6:14 AM, stated follow-up Pain Scale was 0 out of 10 and stated [As needed] Administration was: Effective. The effectiveness of the pain medication was evaluated approximately 12 hours after administration. The standard of practice to evaluate effectiveness of pain medication is between 1 to 2 hours of administration. On 11/12/24 at 02:21 PM, an interview was conducted with Director of Nursing (Staff #2) on the reevaluation of pain after as needed pain medication administration. When asked what the expectation was for the time to reevaluate pain after administration of pain relief medication, Staff #2 stated a resident should be reevaluated for effectiveness 30 minutes after the medication is administered .

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	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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44440 Based on review of the facility's investigation report, record review, and interviews, it was determined that the facility failed to provide a resident with an employee that practiced the appropriate skill set according to their education. This was found evident on 1 (Resident #201) of 7 Residents reviewed for abuse. The findings include: On 11/15/25 at 8:53 AM, the surveyor reviewed Resident #201's medical record. The review revealed that Resident #201 was readmitted to the facility related to multiple falls. Further review revealed a progress note written by Physician #34 on 11/30/24 that reports Resident #201 was very confused at baseline and due to impaired gait and high fall risk a 1:1 sitter was ordered. The surveyor reviewed a summary for provider note written by Registered Nurse (RN)# 35 dated 12/26/23. RN #35 described in the note that she heard the 1:1 sitter shouting out from Resident #201's room. When she entered the room Resident #201 was lying in the bed with his legs hanging out of bed. She further reported she did not know what happened in the room before she entered. On 11/15/24 at 9:10 AM, the surveyor reviewed the facility's investigation file into the alleged abuse reported by Resident #201 from Certified Nursing Assistant (CNA)#32. The file contained a statement from Resident #201 and alleged CNA #32 provided rough care. The surveyor reviewed the statement from Resident #201's roommate Resident #46. Resident #46 witnessed CNA #32 be rough with Resident #201 and reported CNA #32 was grabbing him/her by the wrists, ankles and feet. Resident #46 also stated CNA #32 was slamming Resident #201 into the wheelchair. On 11/18/24 at 9:13 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated the role of a sitter is to monitor and communicate the needs of the Resident with nursing staff. She further clarified that a sitter is not allowed to have direct hand contact with a resident unless they are a Certified Geriatric Nursing Assistant (GNA). The DON confirmed that CNA#32 acted outside of her scope of practice and was terminated related to the incident.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50385 Based on record review and staff interview, it was determined that the facility failed to protect a resident from significant medication errors by inaccurately ordering medications on admission. This was evident for 1 (Resident #197) of 5 residents reviewed for medications. The findings include: On 11/12/24 at 8:53 AM, a review of facility reported incident #MD00189103 was conducted. Resident #197 had a diagnosis of Heart Failure, Chronic Kidney Disease, and Peripheral Vascular Disease. On 2/6/24 Resident #197 was sent out to to a hospital for further evaluation related to confusion, tachycardia, and hypotension. On 2/8/24, the facility identified that the nurse incorrectly entered the medications from the discharge summary into the resident's chart as active medications on the 1/31/23 admission. The medications include the following: - Lasix or Furosemide (a diuretic) - Quetiapine Fumarate (an antipsychotic) - Metoprolol tartrate (a beta blocker used to help lower heart rate and blood pressure) - Sacubitril-Valsartan (used to treat Heart Failure) On 11/12/24 at 9:11 AM, a review of the Medication Administration Record (MAR) was conducted. Metoprolol Tartrate Oral Tablet 100 MG was ordered on 1/31/2023 as Give 1 tablet by mouth one time a day for Blood Pressure. Metoprolol Tartrate was given on 2/4/23, 2/5/23, and 2/6/23 at 9:00 AM. Furosemide oral tablet 40 MG was ordered on 1/31/2023 as Give 1 tablet by mouth three times a day for edema. Furosemide was given on 2/1/23, 2/2/23, 2/3/23, and 2/6/23. Quetiapine Fumarate Oral Tablet 25 MG was ordered on 1/31/23 as Give 1 tablet by mouth at bedtime for Antipsychotic. Quetiapine Fumarate was given on 2/1/23, 2/2/23, 2/3/23, 2/4/23, and 2/5/23. Sacubitril-Valsartan Oral Tablet 49-51 MG was ordered on 1/31/24 as Give 1 tablet by mouth two times a day for Heart Failure. Sacubitril-Valsartan was given on 2/1/23, 2/2/23, 2/3/23, 2/4/23, and 2/5/23 twice a day and once on 2/6/23. On 11/12/24 at 9:30 AM, Resident #197's hospital records prior to admission to Levindale were reviewed. Per hospital MAR the medications being administered while hospitalized were: - Sacubitril-Valsartan 24-26 MG BID. The difference between this and the Sacubitril-Valsartan ordered at Levindale is the dosage. A side effect of this is tiredness, dizziness, and swelling of the face and lips. - Furosemide 40 MG once a day. The difference between this and the Furosemide ordered at Levindale is frequency or how often the medication was given. A side effect of this is Acute Kidney Injury, Low potassium, Low sodium, and dehydration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Metoprolol Succinate 100 MG once a day. The difference between this and Metoprolol Tartrate is the time it takes for the medication to take effect. Tartrate is an immediate release while Succinate is an extended release. A side effect of this is hypotension or bradycardia, low heart rate. - Quetiapine Fumarate 25 MG as needed. The difference between this and the ordered Quetiapine ordered at Levindale is that it was ordered as a scheduled medication to take every day rather than giving it only if the resident has psychotic behaviors or episodes. A side effect of this medication is lethargy. On 11/12/24 at 10:00 AM, Resident #197's hospital record was reviewed. The admitting diagnosis was Sepsis because of an ongoing Urinary Tract Infection (UTI). Sepsis can cause Hypotension, tachycardia, altered mental status, and may cause Acute Kidney Injury. Treatment provided to the resident for sepsis at the hospital resolved these symptoms. On 11/12/24 at 9:42 AM, an interview with Staff #41 in Household 2's nurses' station was conducted. When asked to explain how the Medication reconciliation is done when a resident is admitted from the hospital, Staff #41 stated that the nurse would review the discharge summary and review the medications with the provider. The provider would then accept or deny the medications for the stay at Levindale.