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	11/18/2025

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. Based on observations, review of resident medical records, and interviews, it was determined that the facility failed to ensure that residents' rights to a dignified existence were preserved. This was evident for 3 (Resident #1, #12, and #10) out of 22 residents observed during the complaint survey.The findings include: 1. During observation rounds and interview on 11/13/2025 at 10:45 AM Resident #1 was found in his/her room sitting in a wheelchair wearing a soiled, brown in color substance smeared on the front and outside of, incontinent brief and a white in color t-shirt. Resident's #1 room door was completely open allowing other residents, staff and public visitors to view the resident. Resident #1 pointed to his lower extremities and then pointed to his pants located over by the closet indicating that he/she wanted to be dressed. Resident #1 stated Yes that he/she wanted to be dressed. During observation rounds on 11/14/2025 at 9:55 AM Resident #1 was found in his room, lying in bed, being fed breakfast by staff #4 who was observed standing over resident while talking on his/her cell phone. During an interview on 11/14/2025 at 11:20 AM the Director of Nursing staff #2 and staff #5 were made aware of the concerns found by surveyor with Resident #1 and staff #4. Staff #2 and #5 stated that, it is the expectation that staff are to feed residents sitting down next to residents to provide respect and dignity and not be on their cell phones. Staff #5 also stated that, residents should be dressed and incontinence care provided. 2. A foley drainage bag, or urinary drainage bag, is a medical device used to collect urine from a catheterized resident. The drainage bag is usually worn on the leg or attached to a bed. On 11/13/25 at 7:49 AM, Resident #12 was observed lying in bed with a Foley drainage bag partially filled with yellow liquid. The bag had no privacy cover and was hung on the side of the bed facing the open door, making the drainage bag visible from the hallway. The resident door was open and anyone walking by could see the bag. A second observation on 11/18/25 at 12:13 PM again showed Resident #12 in bed with the Foley drainage bag uncovered, containing yellow liquid, and positioned on the bed frame facing the open doorway, with the bag clearly visible from the hallway. 3. On 11/13/25 at 8:03 AM, Resident #10 was observed in bed with a Foley drainage bag that was partially filled with yellow liquid and not covered. The bag was hung on the side of the bed facing the open door, making it visible from the hallway. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/25 at 2:12 PM, the surveyor observed that Resident #10's catheter bag containing yellow liquid was again uncovered and visible from the hallway. At 2:17 PM, Staff #9, who stated they were covering the resident at that time, was alerted to the dignity concern and acknowledged the uncovered Foley bag. The administrator was made aware of the resident dignity concerns during an interview on 11/18/25 at 2:30pm.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed: 1.) to identify all surrogate decision makers and follow professional standards for surrogate decision making, 2.) to ensure all social work actions taken were documented as part of the resident's medical record, and 3.) to ensure supervision of the work of the Social Work Designee. This was evident for 1 out of 2 Residents (Resident #) reviewed for advanced directives complaint survey.The findings include: On 11/13/25 at approximately 7:45AM the surveyor conducted a review of complaint #2591161 which included allegations expressing concerns regarding the initial facility Social Worker assigned to care of Residents #8 and #9 and allegations expressing concern regarding medical decision making which occurred for Resident #8. On 11/13/25 at 12:00PM the surveyor requested from the Director of Nursing (DON) and facility Administrator to provide the name of the Social Worker which was assigned to Hall 2 Residents. The DON stated the following in response to the surveyor's request: (Staff #23) is the Manager of Social Work, the facility has multiple social work staff for different areas of long-term care. On 11/13/25 at 12:41PM the surveyor conducted an interview with SWM #23 who stated to the surveyor: Hall 2 is (Staff #24) who is the only Social Worker assigned to that unit, s/he is a Social Work Designee. During the interview SWM #23 confirmed with the survey team that there were no Social Work Consultants and no one else that oversees social work. SWM #23 reported that Social Work Designee (SWD) #24 had been on Hall 2 for years. At this time the surveyor inquired to SWM #23 if they had any concerns with social work staff not returning the calls of resident family members; to which they responded: Occasionally, I can't remember if it was any Social Worker in particular. During the interview, SWM #23 confirmed that advanced directives of residents were obtained on admission. On 11/13/25 at 1:04PM the surveyor conducted an interview of SWD #24 and observed their name badge which displayed their job title Social Work Designee. When the surveyor inquired about Residents #8 and #9, SWD #24 responded: Currently I don't have [Residents #8 and #9] my manager [SWM #23] is covering and because of differences my manager [SWM #23] is covering them. During the interview, SWD #24 reported having knowledge of Resident #8 and #9 having lived previously on Hall 1 and that prior to hospitalization they had lived with their son. SWD #24 reported knowledge of the resident's daughter wanting them to stay long term care and having provided communication to them regarding having a brother. SWD #24 reported that Resident #9 was at first the decision maker for Resident #8 upon incapacity being determined, and the daughter became the primary decision maker for Resident #8 because the daughter told them Resident #9 was in the hospital and unable to talk. The surveyor further inquired as to if they made an attempt to contact Resident #9 at the hospital, to which SWD #24 replied: I spoke to someone at the hospital, s/he was unable to talk or I would have spoken to him/her. SWD #24 reported that at the time of Resident #8's admission, they did not know about the resident's son being involved, because my process is, if there's multiple children, to contact both children. The surveyor asked for SWD #24 to provide documentation of an attempt made to contact Resident #8's spouse upon determination of any level of incapacity. SWD #24 responded to the surveyor: No I don't think I wrote a note but I am not sure. The surveyor noted that review of the medical record by the surveyor on 11/17/25 at 8:20AM revealed: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) Paperwork from Resident #8's hospital admission which included a care management initial assessment with contact phone numbers listed for both of the Resident's adult children and summary of the prior living environment which included the Resident's son's involvement, 2.) Resident #8 was admitted to the facility beginning on 4/4/25 and a decision making capacity and treatment limitations form with two medical care provider certifications was dated as completed on 4/8/25 in which Resident #8 was determined to be incapable of decision making for medical care and for financial decisions, There was no medical record documentation that could be found showing that the facility made any attempts to contact Resident #8's son in addition to their daughter, in accordance with surrogacy decision making hierarchy. Review of the medical record revealed that from 4/8/25 until Resident #9's admission on [DATE], the daughter was the only adult child involved by the facility for medical decision making for Resident #8. Review of a social services note with an effective date of 4/16/25 documented a care plan meeting was held by SWD #24 with Resident #8 and their daughter which noted a discussion regarding discharge planning in which Resident #8 having a son was again mentioned with SWD #24 documenting again in the medical record as having reached out for decision making and discussion of discharge plan to the Resident's daughter, There was no medical record documentation that could be found showing that prior to 7/29/25, any attempts were made by the facility's social work department to contact the Resident's son. Review of the medical record by the surveyor revealed a Social Services- Social Worker e-signed note by SWD #24 dated 7/29/25 which documented the following information: SW (Social Worker) explained to son that previously sister was surrogate decision maker due to an error, Son and daughter verbally acknowledged and understood. On 11/17/25 at 8:30AM the surveyor conducted an interview of the facility's Director of Nursing (DON) and SWM #23 and inquired to them as to if they expected for the social work staff to make documented attempts to determine if a resident who is incapacitated has family in order to correctly determine surrogacy. The DON responded to the surveyor's question with: Let's call (SWD #24) first. The surveyor then further inquired to the DON and SWM #23 that aside from calling SWD #24, what their expectations were, at which time the DON stated: Yes, that is the expectation, and SWM #23 stated Yes. At this time SWM #23 made a phone call to SWD #24 who confirmed that not having talked with the son was the error in which was described in their 7/29/25 note. At this time the surveyor shared the concern with SWM #23, SWD #24, and the DON who each acknowledged and confirmed understanding of the concern and error and acknowledged that Social Work Designees should have adequate supervision for the steps they are taking when providing social work support to facility Residents. On 11/17/25 at 10:10AM the surveyor conducted an interview with Manager of Patient Experience #26 who confirmed with surveyors that they had received concerns from Resident #8's son and The daughter was who we had actually been speaking to for any of the concerns, The son he actually called us about when Resident #9 went out to the hospital, we didn't know who he was- so we couldn't give him any information, then we contacted the daughter and she informed us he was her brother and could get information, we called the daughter first because she was listed as the person (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	we should be speaking with. On 11/18/25 at 2:23PM the surveyor shared concerns with the facility Administrator and DON. On 11/20/25 at 10:15AM the surveyor conducted an interview with Ombudsman #25 who reported that previously, SWD #24 had informed them that s/he was the social worker.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, it was determined that the facility failed to ensure an allegation of abuse was reported immediately, but not later than two hours, to the State Survey Agency. This deficient practice was evident for 1 of 5 facility reported incidents reviewed.The findings include: On 11/14/25 at 11:27 AM, a review of the facility's incident report documentation revealed that staff were notified of an allegation of abuse on 8/15/25 at 8:40 AM. The administrator was notified at 9:54 AM the same morning. The initial report to the Office of Health Care Quality (OHCQ) was documented as being made on 8/15/25 at approx. 12 PM, more than two hours after staff were first made aware of the allegation. During an interview with the Director of Nursing (DON) on 11/14/25 at 12:50 PM, she was made aware that the allegation had not been reported within the required two-hour time frame and she stated that she would check the submission record and follow up. At 1:05 PM, the DON returned and confirmed that the report had been submitted late.

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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. Based on review of a Facility Reported Incident (FRI), record review, and interview with staff, it was determined that the facility failed to maintain documentation of a thorough investigation. This was evident for 1(#329731) out of 5 FRI's reviewed during the complaint survey. The findings include:During a review of FRI #329731 and the facility's investigative file on 11/13/2025 at 10:50AM, the Surveyor discovered that on 6/17/2025 at approximately 3:55PM, Resident #7 eloped. An elopement alert, code grey, was initiated over the loudspeaker at about 4:15PM and full sweep of the facility and surrounding areas were searched. Campus security was immediately notified. At about 4:30PM, the police and transit authority were notified. Resident representative notified. The resident returned to the facility at approximately 6:25PM.A review of the Facility Reported Incidents Follow-Up Investigation Report revealed the facility verified the elopement in the conclusion by stating [Resident #7] did leave the facility but was found shortly after. The facility failed to include the circumstance leading up to the resident's elopement, how the facility determined how the resident exited the facility, and how, when, and where the resident was found. Corrective actions were limited to patient was placed on a1:1 sitter.An additional review of the investigative file revealed a Nurses Note dated 6/17/2025 at 6:48PM with the nurse's depiction of the incident stating that the resident was located by police at 6:15PM and escorted back to the facility. A Behavioral note written by Unit Manager (UM) #10 dated 6/17/2025 at 8:33PM with the nurse's depiction of the incident and their involvement in the search for the resident. There was one staff statement, which was unsigned and did not identify the staff member's title. There were no other staff statements or evidence of interviews conducted with staff. There was no evidence of an interview with the resident or any other resident who resided on the unit with Resident #7.During a review of Resident #7's electronic medical record conducted on 11/13/2025 at 11:00AM, the failed to reveal documentation of how the resident was able to exit the unit and the facility.On 11/14/2025 at 11:48AM, during an interview with the Director of Nursing (DON) and the Administrator, the Surveyor expressed the concern that the investigative failed to identify any evidence as to how the facility determined the circumstances of the resident having eloped and how the resident exited the unit and the building. The Surveyor also expressed the concern that the corrective measures implemented, as stated in the follow up report only included a 1:1 sitter. The DON informed the Surveyor that they reviewed camera footage and were able to determine that Resident #7 was able to elope because a staff member did not ensure the doors were fully closed behind them when they exited the unit. Per film, the resident waited until the staff member exited HH 5 doors, went to the door, held it open with their foot, and waited until the staff member entered HH 6. The resident then slipped out the door quickly and proceeded to the elevators. Once on the 1st floor, the resident exited the facility through the double doors to the left of the main entrance doors. The resident caught an MTA bus downtown, where the resident was found by police. Resident #7 returned to the secure unit in HH 5. The facility staff implemented 1:1 sitter for a week and then 1:1 rounding observation sitter for supervision, 7am and 7pm huddle meetings to inform staff of the elopement and increased supervision of the residents at risk for wandering/exit seeking. The staff member was educated to wait for the all unit doors to fully close behind them before walking away, staff continue to receive education on elopement risk resident and identifying exit seeking behaviors. The Surveyor reiterated the concern that this information was not included in the investigative file or in the resident's electronic medical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff, it was determined that the facility failed to develop and implement a person-centered care plan for a resident who has eloped. This was evident for 1 (Resident #7) out of 16 residents reviewed for wandering/elopement during the complaint survey. The findings include:A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the Interdisciplinary team after the completion of a comprehensive Minimum Data Set assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility.Elopement is when a person leaves the premises or a safe area without the facility's knowledge and supervision.On 11/13/2025 at 10:25AM, during a review of Facility Reported Incident #329725 and the facility's investigative file on, the Surveyor discovered that on 3/6/2025 at 3:04PM Resident #7 eloped.A review of Resident #7's electronic medical record on 11/14/2025 at 12:20PM, revealed a Behavior Note dated 5/2/2025 which stated at approximately 9am [Resident #7] followed a staff thru the locked door and went down the elevator towards the front door, [the resident] was brought back to [his/her] room and assessed a WNL, [the resident]was asked not to sit by the door.On 11/13/2025 at 10:50AM, during a review of FRI #329731 and the facility's investigative file the Surveyor discovered that on 6/17/2025 at approximately 3:55PM, Resident #7 eloped again. On 11/14/2025 at 2:30PM, during a review of Resident #7's electronic medical record the Surveyor discovered that the resident had been transferred to the specialty hospital on 8/5/2025 and was readmitted to the facility on [DATE]. On 10/30/2025, the facility initiated a care plan with a focus, Resident is at risk for elopement related to Dx of Unspecified dementia with other behavioral disturbance, a goal, [Resident] will not successfully elope from the facility and will have whereabouts monitored on an ongoing basis through the next review date, and Interventions: Wander guard to the left ankle Monitor each shift every shift for Elopement risk (initiated on 10/31/2025), and Monitor [Resident] for tailgating when visitors are on the unit. A review of the care plan failed to identify and reflect that the resident had actual elopements from the facility on 3/6/2025 and 6/17/2025, and an elopement off the secured unit on 5/2/2025, and failed to include resident specific interventions based on identified triggers, enhanced monitoring including behaviors, redirectional activities, wander risk assessments, and the increased need for supervision such as 1:1 rounding supervision as ordered.On 11/17/2025 at 2:28PM during an interview with the DON and the Administrator, the Surveyor was informed that safety measures were put into place when the resident returned from the specialty hospital 10/29/2025. The resident was admitted to the secured nursing unit, a wander guard bracelet was placed on the resident, and the resident was supervised by staff including a 1:1 non-clinical observation sitter at all times.

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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** Based on record review and interviews, it was determined that the facility failed to revise the care plan to meet the needs of a resident identified as a high wander risk. This is evident for 1 (Resident #5) of 16 residents reviewed for wander/elopement risk.The findings include: On 11/14/25 at 11:12 AM, a review of the electronic medical record showed that Resident #5 had a Wander Risk Score of 13, with scores above 11 indicating high risk, based on an assessment dated [DATE]. Resident #5's care plan, initiated 4/3/25 and revised on 5/1/25, identified the resident as resistive to care and exhibits wandering related to adjustment to nursing home. Despite this high-risk score and documented wandering behaviors, the care plan was not revised to include interventions addressing increased risk and the need for increased supervision. During an interview on 11/14/25 at 1:14 PM, the DON and NHA confirmed that Resident #5 was not included on the wander list and that the required quarterly assessment had not been completed since 6/27/25. The concerns with the lack of care plan interventions appropriate to the resident's high Wander Risk score and the lack of revision to the care plan after the assessment on 6/27/25 were brought forward at this time. On 11/17/25 at 8:29 AM, the overdue wander risk assessment was found to have been completed on 11/14/25, after surveyor identification. Resident #5 now had a Wander Risk Score of 17, indicating a higher risk than on the previous assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview with staff, it was determined that the facility failed to : 1.) ensure residents had physician orders for placement of a WanderGuard device (sensor bracelet) and facility staff were checking the WanderGuards for function. This was evident for 3 (Resident #17, #18, and #19) out of 16 residents reviewed for wandering/elopement; 2.) ensure adequate supervision and monitoring for a resident with documented wandering behaviors and an identified high wander risk, and ensure significant changes in vital signs were recognized, reported, and acted upon. This was evident for 1 (Resident #5) of 2 residents reviewed; 3.) ensure the resident received timely necessary care in response to a resident's change of condition (Resident #4); 4.) ensure necessary incontinence care was provided as well as timely response to resident calls for assistance, and ensure interventions on the care plan for diet were appropriately reflected in the medical diet orders (Resident #8 and #9). This was evident for 2 out of 3 Residents reviewed for quality of care. The findings include: 1a. Wandering is random or repetitive locomotion; this movement may be goal directed (e.g., the person appears to be searching for something such as an exit) or may be non-goal directed or aimless and can significantly increases the risk of injury to the individual. Elopement is when a person leaves the premises or a safe area without the facility's knowledge and supervision. On 11/13/2025 at 1:15PM, the Surveyor reviewed the Identifying Risk for Patient Wandering and Use of the WanderGuard System policy with an effective date of 11/13/2025. According to the policy, the facility should obtain a physician's order for the implementation of a WanderGuard device (sensor bracelet) for a resident. On 11/14/2025 at 10:30AM, during a review of the Wander/Elopement Risk List and review of the electronic medical record, the Surveyor discovered that Resident #17, #18, and #19 did not have physician's orders for a WanderGuard device. On 11/14/2025 at 11:30AM, during an interview and observation tour conducted with Licensed Practical Nurse (LPN) #8, the Surveyor confirmed the placement of WanderGuard devices on Residents' #17, #18, and #19. During an interview conducted with the Administrator on 11/14/2025 at 1:40PM, the Surveyor expressed the concern that Resident #17, #18, and #19 had a sensor bracelet on and failed to have documentation of a physician's order for them. The Surveyor was informed that any resident with a WanderGuard device, should have a physician's order for placement. The Administrator was asked to provide documentation of a physician's order for placement of a WanderGuard device on Resident #17,#18, and #19. On 11/17/2025 at 10:45AM, the Administrator confirmed that Resident #17, #18, and #19 did not have a physician's order for a WanderGuard device and provided documentation of new physician's orders placed on 11/14/2025 for the Residents #17, #18, and #19. 1b. On 11/13/2025 at 11:25AM, the Surveyor conducted an interview with Licensed Practical Nurse (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(LPN) #22 who was working on a secured unit, household (HH) 5. During the interview, the Surveyor was informed that residents wearing a WanderGuard device (sensor bracelet) are reported to the on coming nurse during shift report. Nurses are to check the WanderGuard device for placement and document in the resident's electronic medical record each shift. Nurses do not check the resident's WanderGuard device for function. During an interview conducted with the Director of Maintenance (DOM) #7 on 11/13/2025 at 12:10PM, the Surveyor was informed that the WanderGuard electronic monitoring system was a new system for the facility. It was installed and fully functioning throughout the facility by the end of September 2025. The maintenance department was responsible for checking the function of the exit sensor alarm system and that is tested daily. Maintenance staff do not test the resident's individual sensor bracelets for functioning. On 11/13/2025 at 1:00PM, a review of Testing You WanderGuard BLUE System Correctly: Important Information guide revealed that WanderGuard device bracelets should be tested daily and more frequently for residents who are known to tamper with their bracelets. The results should be documented in the resident's electronic medical record. On 11/13/2025 at 1:40PM, an interview with the Director of Nursing (DON) revealed that the WanderGuard system was new to the facility. All staff are still learning the new system. At this time, the nurses are checking the residents to ensure the WanderGuard device placement on the resident and that is documented in the electronic medical record. The nurses are not testing the residents' devices to make sure they are functioning. On 11/14/2025 at 1:30PM, during an interview with the Administrator and the DON, the Surveyor expressed the concern that the facility does not conduct routine testing of the resident's individual bracelets to ensure they are functioning and that the nurses are just checking for placement. The Surveyor was informed that the facility was currently working on the concern. On 11/17/2025 at 2:28PM, the Administrator reported that the maintenance department will be checking the function of the residents' individual WanderGuard device daily and documenting the results in a maintenance log. 2a. On 11/14/25 at 11:12 AM, review of the electronic medical record identified a Wander Risk Score of 13 dated 6/27/25, indicating the Resident #5 was at high risk for wandering. At 1:07pm, during review of Resident #5's care plan, it was revealed that the care plan was initiated on 4/3/25 and revised 5/1/25. It was documented that the resident is resistive to care and exhibits wandering related to adjustment to nursing home. During an interview on 11/14/25 at 1:14 PM, the DON and NHA confirmed that Resident #5 was not included on the facility's wander list, and that a quarterly assessment for wander risk for Resident #5 was past the date required to complete an updated assessment. On 11/17/25 at 8:29 AM, record review showed the wander assessment had been completed on 11/14/25, after the surveyor identified the missing quarterly assessment.The failure to reassess the resident for wandering risk and to provide increased supervision placed the resident at risk for unsafe wandering or potential elopement. 2b. On 11/17/25 at 10:25 AM, review of the electronic medical record revealed Resident #5's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature was recorded as 35.7 degrees C (96.26 Fahrenheit) by Staff #27 with no documented significant change in condition assessment, recheck, or provider notification. A review of the electronic medical record further showed that on 11/9/25, two separate GNAs recorded a temperature of 33.6 degrees C (92.48 Fahrenheit), first at 8:44 AM by Staff #20 and again at 10:21 AM by Staff #27. No documentation of licensed nurse notification, follow-up, recheck, or provider notification was found for either reading. On 11/17/25 at 10:50 AM, interviews were conducted with the Director of Nursing (DON) and the nursing home administrator (NHA). When asked what the accepted temperature range was, both the DON and NHA were unsure. The DON confirmed that 35.7 degrees C (96.26 Fahrenheit) was outside the acceptable range. When asked what staff were expected to do when vital signs fell outside of the acceptable range, the DON stated the expectation was that the GNA would notify the nurse, who should then notify the provider. The DON stated that the procedure was for GNA's to report abnormal vital signs to the licensed nurse, who would then contact the provider. At this time the surveyor requested the facility's written policy and clarification of how the GNA determined what was reportable to the nurse, where parameters could be located for reference, and written policy used by the facility. As of 1:49 PM the same day, no documentation of any recheck of Resident #5's vitals or further follow-up had been received. On 11/18/25 at 12:44 PM, review of the facility policy provided by the DON titled Reporting Changes in Condition stated, The GNA is responsible for notifying the licensed nurse, the licensed nurse is responsible for notifying the nursing supervisor, the physician and responsible party for any significant change in condition and documenting this notification on the Change in Condition form. The policy did not contain specifics about what should be reported regarding actual vital signs. During a subsequent interview with the DON, when asked how the GNAs know of the acceptable vital sign parameters and which findings should be reported, she stated, The GNA's should just know. The surveyor again shared the concern regarding the low temperatures documented on 11/9/25 by two different GNAs (both at 33.6 degrees C) and the lack of documentation showing that the nurse assigned to the resident had reviewed or acted upon these findings. 3. On 11/13/25 at 9:15AM the surveyor conducted a review of complaint #329723 which alleged that Resident #4 had to be evaluated elsewhere for them to get properly cared for relating to a change of condition of the Resident that occurred in January of 2025. Review of the medical record of Resident #4 by the surveyor on 11/13/25 at 9:29AM revealed that on 1/15/25 the Resident was assessed by Certified Registered Nurse Practitioner (CRNP) #12 in response to abnormal lab results documented as suggestive of a bacterial infection during which time Resident #4 was documented as not feeling well, reported pain, blood pressure issues and decreased appetite to CRNP #12 and a chest x-ray was ordered. Review of the chest x-ray results dated as reported on 1/15/25 at 11:01PM revealed the following documentation: Impression: 1.) Multifocal patchy nodular opacity/infiltrates Review of the medical order by the surveyor on 11/13/25 at 9:29AM revealed the Levofloxacin antibiotic was entered on 1/16/25 by CRNP #12 and would not begin until 1/17/25 at 10:00AM, and was ordered to be given every 2 days for Pneumonia for 5 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the SBAR communication form utilized by nursing staff to notify the primary care clinician on 1/17/25 at 8:40AM revealed the following provider recommendation in response to the nurse's report of change in condition of Resident #4: Give STAT (immediate, with no delay) dose Levaquin 750mg/UTI, call 911 transport to ER r/o (rule out) sepsis. Review of the January 2025 medication administration record revealed there were no antibiotics administered to Resident #4 prior to their transfer to the hospital on 1/17/25. On 11/13/25 at 10:20AM the surveyor conducted an interview with CRNP #12 who reported to the surveyor that they reviewed Resident #4's x-ray result on 1/16/25 which revealed pneumonia and that day they ordered the Levaquin antibiotic; when the surveyor inquired to CRNP #12 as to if they ordered antibiotics for administration right away, or for them to begin the next day, they stated: No we don't wait, we order and schedule for right away. CRNP #12 stated to the surveyor during the interview that: My order (antibiotic) was put in on 1/16, I reviewed the x-ray result on the 1/16, but it seems like they didn't give it (antibiotic) but I don't know why the nurse didn't give it. On 11/13/25 at 10:55AM the surveyor shared the concern with the facility Administrator and Director of Nursing (DON). On 11/13/25 at 11:13AM the surveyor conducted an interview with the DON who reported to the surveyor that the Resident's antibiotic had not been given because they were sent to the hospital at 9:15AM. The surveyor noted that the SBAR communication form was documented at 8:40AM for the STAT (immediately, with no delay) dose to be given to the Resident. When the surveyor inquired to the DON as to if the Levaquin antibiotic medication was on hand and would have been able to be immediately pulled and given to the resident, they replied: Yes. On 11/13/25 at 11:19AM the surveyor conducted an interview of Licensed Practical Nurse (LPN) #13 who was assigned to Resident #4's care on 1/16/25, who reported the following information to surveyors regarding the antibiotic order dated 1/16/25 but not having a begin date until 1/17/25: Honestly it didn't click, I just confirmed the order, It was to start on 1/17 at 10:00AM. During the interview, LPN #13 and the DON presented the surveyor with a copy of the January 2025 medication administration record and LPN #13 pointed to the documentation for the Levaquin antibiotic and stated: The antibiotic was given. At this time, the surveyor reviewed the documentation which did not indicate the medication had been given, the administration for the antibiotic that morning had been coded with a #6. When the surveyor inquired to the DON as to what a #6 code on the medication administration record meant, they stated: Code 6 means it was not given. At this time, both the DON and LPN #13 confirmed the antibiotic was not given and both the DON and LPN #13 acknowledged and confirmed understanding of the surveyor's concern. On 11/13/25 at 11:28AM the surveyor conducted another interview of CRNP #12 who stated the following information to surveyors: I expected the nurse to give the antibiotic on the evening of 1/16/25. Review of the medical record of Resident 14 on 11/13/25 at 11:42AM revealed the following transfer to hospital summary note dated 1/17/25 at 9:19AM: This morning during my rounds the aide noticed (Resident #4) was shaking and coughing, I then went to assess (Resident #4), his/her vitals were 92/66, HR (heart rate) 114, respirations was 22, O2 was 87, then (Resident #4) was given 02 at 3liters 02 went to 93, FS was 163, (CRNP #12) was notified and said to send (Resident #4) out 911, family was also notified, 911 arrived and patient was transferred to (Hospital). Further review of the medical record revealed a clinic note documented by Geriatric Nursing Assistant #14 on 1/17/25 at 4:38PM: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Resident #4) was transfer to (hospital) for change in mental status, fever, and shaking. On 11/18/25 at 2:23PM the surveyor shared the concern with the facility Administrator and DON. 4a. On 11/13/25 at approximately 7:45AM the surveyor conducted a review of complaint #2591161 which included allegations regarding incontinence care issues of Residents #8 and #9, concerns for the timeliness of care being provided by facility staff, and concern for resident diet plans being followed. On 11/13/25 at 12:00PM the facility's Director of Nursing (DON) confirmed with surveyors during an interview that their expectation of timely incontinence care meant providing the care within ten to fifteen minutes of the request having been made. During an interview conducted by the surveyor on 11/13/25 at 12:00PM the surveyor inquired to both the Administrator and Director of Nursing as to if they had received any concerns brought to their attention regarding staff being disrespectful, unhelpful, and/or unprofessional since August 2025, to which the Administrator responded: We have a customer service excellence team, I can get them for you. At this time, the surveyor further inquired to the Administrator, that aside from the customer service team, had they or the DON received any concerns from resident family members regarding staff being disrespectful, unhelpful, and/or unprofessional since August 2025, to which they then responded: Unofficially, yeah, I've received concerns. Not concerns of being disrespectful. During the interview the DON reported the following information: I have been told residents wait too long for assistance, if I have the employee's name, I investigate the employee, I pulled the call lights history and one was 7 minutes, one was 27 minutes, I addressed that staff member. During the interview the Administrator reported the following information to surveyors: Our main concern we hear is there is not enough staff, I'm sure other places are having that issue also. During the interview the DON stated to surveyors: We've had customer service issues that were addressed with staff. On 11/13/25 at 12:34PM the surveyor requested call bell timeliness reports from the facility's Administrator for four resident rooms on Hall 2 of the facility. On 11/13/25 at 1:04PM during an interview conducted by the surveyor, the DON reported that regarding care concerns for Residents #8 and #9 no formal grievance had been filed, however, complaints and issues brought to them were addressed, some were valid, some were not. After several repeated requests for the call bell timeliness reports from the facility's Administrator and DON, on 11/17/25 the surveyor was provided with two of the four requested room's call bell timeliness reports. Review of the call bell reports for the two rooms provided, revealed that on approximately 32 occasions of call bell requests for assistance, the report documented the response time to be greater than fifteen minutes. Review of Resident #9's care plan revealed the following goal was present to address incontinence which documented as initiated on 6/17/25, revised on 8/11/25, with a target date of 2/1/26: (Resident #9) Will be clean, dry and odor free every day for the next two weeks. On 11/17/25 at 11:00AM the surveyor conducted an interview with Resident #8 and Resident #9. Resident #8 stated the following information regarding timeliness of call bell response with regard to incontinence care: Sometimes it's a long time we have to wait, sometimes 45 minutes to 1 hour. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/17/25 at 11:59AM the surveyor conducted an interview with the Manager of Wound Care Treatment Team, Registered Nurse who was also performing the role of Interim Unit Manager (IUM) #5 for Hall 2. IUM #5 reported to the surveyor during the interview that Resident #8 and #9's family member had shared their concern regarding incontinence care with them and when the surveyor inquired as to if the concern shared with them was investigated, they stated to the survey team: No. When the surveyor inquired as to what actions were taken in response to the family member's concern, IUM #5 stated: I just made sure they cleaned her up and told them (the staff) not to leave him/her soiled. When the surveyor inquired to IUM #5 as to if Resident #9 had been left soiled, they reported they did not know if the resident had been left soiled. The surveyor conducted an observation of Residents #8 and #9 on 11/18/25 at 8:13AM at which time Resident #8 reported to the surveyor that they needed staff to provide incontinence care. On 11/18/25 at 8:15AM the surveyor conducted an interview of Registered Nurse (RN) #15 assigned to the care of Residents #8 and #9 who stated the following information to the surveyor regarding incontinence care provided to the residents: Prior to shift change residents are rounded on by the overnight geriatric nursing assistants (GNA's) and staff before shift change to ensure they are clean and dry. At this time the surveyor informed RN #15 of the resident's request for incontinence care and observed RN #15 go into Resident #9's room and stated to the resident: I'll go find the GNA to help you to get changed. When the surveyor inquired to RN #15 as to if they had some other task going on at this time, RN #15 stated: It's shift change, I'll go get the GNA assigned to him/her. At this time, the surveyor asked for RN #15 to show this surveyor the medical record documentation of the last time that Resident #9 had been provided with incontinence care, at which time RN #15 reported that the surveyor would have to ask IUM #5 to observe the documentation. On 11/18/25 at 8:16AM the surveyor observed RN #15 inform GNA #16 and GNA #17 that Resident #9 needed incontinence care. At this time the surveyor conducted an interview of GNA #16 and GNA #17 who confirmed with the surveyor that if they are unable to document directly after each incontinence care performed, the documentation happens at a different time other than when the incontinence care was given. At this time, both GNA #16 and #17 confirmed the facility's expectation was for them to document each time incontinence care is provided. On 11/18/25 at 8:24AM the surveyor conducted an observation of the incontinence care status of both Resident #8 and Resident #9. At this time, Resident #9 was observed to be wearing a heavily saturated wet yellow incontinence brief. Both GNA #16 and #17 confirmed they were familiar with providing care to Resident #9 and GNA #16 reported they hadn't been changed like they were supposed to be overnight, and reported that they would be letting IUM #5 know about it because the Resident should've been changed. IUM #5 was then observed entering the room and confirmed with the surveyor that they had observed Resident #9's very wet brief. IUM #5 informed the surveyor that they would be contacting GNA #18 who was the overnight GNA assigned to the Resident and a disciplinary action would be given to them. On 11/18/25 at 8:30AM the surveyor requested for IUM #5 to show this surveyor documentation of the last time Resident #9 was provided with incontinence care. This surveyor observed IUM #5 open the electronic health record (pcc), and IUM #5 asked this surveyor what the Resident's name was. This surveyor provided Resident #9's name and IUM #5 was unable to figure out how to see if incontinence care was provided or not, and stated they were Interim Unit Manager since October 2025 and had worked for the facility for approximately 5.5 years. IUM stated to this surveyor I am not familiar with PCC, I'm calling the DON. I'm still learning. This surveyor observed IUM #5 call the DON to ask how to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	check when the last time a Resident was changed in the computer system. IUM #5 ended the call and stated the DON was coming to show them how. IUM #5 stated to the surveyor: Residents should be rounded on for incontinence every 2 hours and are supposed to be changed. On 11/18/25 at 8:34AM the surveyor observed the incontinence status of Resident #8 who was observed to have a mildly saturated incontinence product in place. On 11/18/25 at 8:35AM the DON showed this surveyor the incontinence care documentation which revealed that point of care documentation was not occurring, facility staff documentation for incontinence care consisted of a once per shift sign off documentation that incontinence care was performed for the shift. Documentation of how many times and when the Residents were changed throughout the shift was not observed to be present. The DON was observed teaching IUM #5 how to observe incontinence care documentation in the medical record. The DON reviewed the incontinence care documentation of Resident #9 and reported to the surveyor regarding the facility staff's care of the resident: This is not acceptable. On 11/18.25 at 8:40AM the DON informed the survey team that staff are only expected to document every shift. The surveyor inquired to the DON as to if all incontinence care that is provided during the shift was not expected to be documented; to which the DON replied: I am unsure, I have to check on this. On 11/18/25 at 11:32AM the surveyor conducted an interview of GNA #20 who reported to the surveyor that From my GNA training, you document at point of care, care is provided and care is then documented after. On 11/18/25 at approximately 11:35AM the surveyor conducted an interview with Licensed Practical Nurse #19 who stated to the surveyor: Residents do have to wait sometimes, because of staffing when people call out. On 11/15/25 at 11:58AM the surveyor conducted an interview with the DON and inquired as to where specifically, incontinence care was to be documented in the medical record. During the interview, the DON reported to the survey team that the expectation was: Staff are supposed to be rounding every two hours to make sure the person is clean and dry, the staff know that. On 11/18/25 at 12:30PM the surveyor conducted an interview with the DON and inquired as to how the rounding every two hours was documented; at which time the DON responded to the survey team: I don't know, I have to find out. 4b. On 11/17/25 at 12:26PM the surveyor conducted an interview of Director of Food and Nutrition #21 who stated the following information: The PCC (point click care electronic health record system) medical order directs and produces the meal ticket for the kitchen. Surveyors confirmed during the interview that the selected diet is what directs the type of diet that populates onto the meal ticket, the information entered in the directions section of the order does not populate on the meal ticket. On 11/17/25 at 2:42PM the surveyor reviewed the medical record which revealed the following information: Resident #9's care plan documented a focus on decreased nutrient needs for carbohydrate/concentrated sweets and sodium relating to their diabetic diagnoses with a history of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intermittent hyperglycemia and hypertension with an intervention of providing a therapeutic diet initiated on 6/6/25 with the supporting diet order of a controlled carbohydrate and heart healthy diet Diet order history of Resident #9 having received only a heart healthy diet from 6/7-7/17/25 with directions written in the order for low sodium, diabetic heart healthy and low fat, and a regular diet from 7/18-7/20/25. On 11/18/25 at 2:23PM the surveyor shared concerns with the facility Administrator and DON.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Facility Reported Incident (FRI) #329725 and #329731, resident medical records, and other pertinent documentation, interviews with staff, and observations, it was determined that the facility failed to prevent a cognitively impaired resident with known exit seeking/elopement behaviors from exiting the facility on two occasions. This was evident for 1 (Resident #7) out of 16 residents reviewed for wandering/elopement during the complaint survey. This failure resulted in an Immediate Jeopardy for Resident #7.The facility implemented effective and thorough corrective measures following this incident. The facility's plan and actions were verified during this survey, therefore this deficiency will be cited as past noncompliance. The date of correction was 6/17/2025. The findings include: On 11/13/2025 at 10:00AM, a review of Resident #7's electronic medical record revealed that the resident had a diagnoses of but not limited to dementia with agitation, anxiety, and behavioral disturbance, schizoaffective disorder, bipolar type, drug induced parkinsonism, and epilepsy. The resident was admitted to a secured nursing unit of the Long Term Care facility on 1/22/2025 for cognitive impairment and worsening psychosis. The resident was independent with ambulation. A review of an admission Wandering Risk Assessment completed 1/22/2025 revealed a score of 0, indicating the resident was not a wandering risk. However, a review of a nursing progress note dated 1/23/2025 at 7:04PM stated the resident was busy seeking exit and wanted to go to floor 2 and go home. According to the admission Minimum Data Set (MDS) assessment completed 1/28/2025, the resident had a Brief Interview for Mental Status (BIMS) score of 0, which indicated severe cognitive impairment.Further review revealed a care plan with a focus, [Resident #7] is at risk for elopement/wandering related to cognitive impairment initiated on 1/24/2025 with interventions to Monitor [Resident] for tailgating when visitors are on the unit, Provide direct staff supervision when attending out of facility activities, Reassess elopement risk quarterly, and Use verbal and if necessary physical cues for redirection to persuade exit-seeking behaviors. Review of Facility Reported Incident #329725 and the facility's investigative file on 11/13/2025 at 10:25AM, revealed that on 3/6/2025 at 3:04PM, after participating in a group activity in the Town Center on the first floor, Resident #7 exited the facility through the [NAME] doors to the right of the main entrance while activity staff were escorting other residents to their units. The resident was discovered missing at about 3:15PM. Facility staff conducted an initial search for the resident in the Town Center, on the resident's Household unit, and all Household units. Unit Manager (UM) #10 for the Household units and the Director of Nursing (DON) were informed and called a code grey at about 3:20PM. Staff searched the entire facility, including the outside of the facility and surrounding areas. Campus Security and Maryland Transit Administration (MTA) were notified. The resident representative was notified at 4:11PM. The police were called and given a description of the resident. Based on a statement made by the Chief Administrative Officer #11, on 3/6/2025, after reviewing security film, Resident #7 exited the building via the double doors to the left of the main entrance. At 3:16PM the resident boarded an MTA bus. Later that evening, around 8:00PM, the facility was notified that Resident #7 had just arrived at the hospital via ambulance. The resident was later admitted to the hospital for observation and evaluation. The resident sustained no injuries. The resident was readmitted to the facility on [DATE].A review of Resident #7's electronic medical record on 11/14/2025 at 12:20PM, revealed a Behavior Note dated 5/2/2025 which stated at approximately 9am [Resident #7] followed a staff through the locked door and went down the elevator towards the front door, [the resident] was brought back to [his/her] room. During a review of FRI #329731 and the facility's investigative file on 11/13/2025 at 10:50AM, it was revealed that on 6/17/2025 at approximately 3:55PM, Resident #7 eloped again. An elopement alert, code grey, was initiated over the loudspeaker at about 4:15PM and full sweep of the facility and surrounding areas were searched. Campus security was immediately (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	notified. At about 4:30PM, the police and transit authority were notified and the resident's representative. During a review of Resident #7's electronic medical record conducted on 11/13/2025 at 11:00AM, the Surveyor discovered a clinic note dated 6/17/2025, written by the UM #10, which stated that at around 3:10PM, the nurse called UM #10 to inform her that Resident #7 wants to go out for a walk, and she needed help to get the resident out. At around 3:44PM, the nurse called UM #10 to inform her that Resident #7 was nowhere to be found. UM #10 called an elopement alert, code grey when she arrived on the unit. The nursing team searched all the rooms on Household (HH) 5, and the stairways. Other staff searched the entire interior and exterior of the building. The nurse called 911 and the resident representative to notify them of the situation. The resident could not be located. At around 6:14PM, the police officer who remained at the facility, notified the facility that the resident had been located downtown. Upon UM #10's arrival to pick up the resident, the resident informed the Unit manager of unit 5 that they wanted to go to their house downtown and wanted to go home. The resident returned to the facility with UM #10 and was returned to Household 5, a secured unit. The resident was assessed and had sustained no injuries and had no complaints of distress. During observation rounds on 11/13/2025 at 11:30AM, the Surveyor observed HH 5. The staff had to use their badges for entry into the unit and exit. There were multiple signs on the doors which stated High Elopement Risk in bold red letters. A sign to inform visitors and staff to DO NOT open door when residents are standing near or at them. Please wait for a safe time to enter. Thank you for ensuring the doors close safely behind you upon your exit. Another sign in capital red letters and highlighted in yellow which states, Attention all staff and visitors. You must stop and wait for the door to completely close before walking away. Another sign with SAFETY that states High Elopement Risk; Prevent unsafe departures; Ensure door fully closes before walking away. A wander guard electronic system with exit sensors was observed at the doorway. During a continued tour of the facility 11/13/2025 at 11:40AM, the Surveyor noted that there was a wander guard system with exit sensors located on the doors at the main entrance and on the double doors to each side of the main entrance doors. The doors to the right of the main entrance, labeled [NAME] doors, have an Exit sign and allows someone to exit the facility but not enter the facility (unless it is [NAME] days). The doors to the left of the main entrance, have an Exit sign and allows someone to exit the facility but not enter the facility. During an interview conducted with the Director of Maintenance (DOM) on 11/13/2025 at 12:10PM, the Surveyor was informed that the WanderGuard electronic monitoring system was a new system for the facility. It was installed and fully functioning throughout the facility by the end of September 2025. There were exit sensor alarms and keypads at all the doors which enter and exit each unit of the facility. There are exit sensor alarms at the main entrance sliding doors and the double doors to the left and the right of the main entrance doors. The maintenance department was responsible for checking the function of the exit sensor alarm system and that was tested daily. The DOM informed the Surveyor that they were aware of Resident #7's elopement on 6/17/2025. In response to Resident #7's elopement, the maintenance department staff tested the doors on HH 5 to ensure it was magnetized and closed properly, they tested the time the doors closed and tested the hardware of the door. The doors of HH 5 were functioning properly. On 11/14/2025 10:45AM, the Surveyor reviewed a wander/elopement risk list provided by the facility. The Surveyor identified the location of the 16 residents listed. During a tour of the facility, a Surveyor observed Hall 1, Hall 2, HH 1 and HH 2 on the first floor, HH 3 and HH 4 on the second floor, and the secured units HH 5 and HH 6 on the third floor to ensure the wander guard system exit sensors and keypad were at each entry and exit to the units. The Surveyors observed High Elopement Risks signs on the inside and outside the doors at HH 3, HH 4, HH 5, and HH 6. A Surveyor confirmed the placement of a wander guard electronic bracelet for the residents listed on Hall 1 and Hall 2. On 11/14/2025 at 11:30AM, during an interview and observation conducted with Licensed Practical Nurse (LPN) #8 working on HH 5 and HH 6, the Surveyors confirmed the placement of the wander guard electronic bracelet for each resident on the wander/elopement risk list who resided on those units. During the tour of HH 5 and HH 6, LPN (continued on next page)

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	11/18/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#8 made sure the unit doors closed behind her before proceeding to the next unit. The stairways doors, on both units, do not have wander guard system exit sensors in place. LPN #8 informed the Surveyors that those doors can only be accessed by facility staff via keypad and badge. LPN #8 demonstrated how the wander guard electronic monitoring system works. The Surveyors observed a resident approach the unit door on HH 5, the resident's electronic bracelet activated exit sensors and the keypad started to alarm and display the bracelet's tag # assigned to that resident. A staff member approached the unit door on HH 5 with another resident, with an electronic bracelet on, who was in a wheelchair. As the staff member opened the doors with her badge, the resident's electronic bracelet activated the exit sensor and a loud alarm sounded. LPN #8 deactivated the alarm using the keypad. During an interview conducted with the Director of Nursing and the Nursing Home Administrator (NHA) on 11/14/2025 at 1:30PM, the Surveyor was informed that Resident #7 was ambulatory and very active at the time the resident eloped on 3/6/2025. As a result of the Resident #7's elopement, staff completed a head count of all residents, the facility implemented larger, more bold signs on the doors for staff and visitors, elopement education was initiated for all staff, elopement drills were initiated, Wandering Risk Assessment reinitiated for all residents in the facility, and effective immediately, all activities were held on HH 5 and HH 6 for the residents who reside on those units, and 7am and 7pm unit huddle meetings were held to inform staff of the elopement and to provide increased supervision for wandering/exit seeking residents. Upon readmission, Resident #7 returned to the secured unit on HH 5 and the resident was 1:1 with rounding observation sitter, and redirection activities. During a continued interview, the NHA reported that on 6/17/2025 Resident #7 was able to elope because a staff member did not ensure the doors were fully closed behind them when they exited the unit. Per security film, the resident waited until the staff member exited HH 5 doors, went to the door, held it open with their foot, and waited until the staff member entered HH 6. The resident then slipped out the door quickly and proceeded to the elevators. Once on the 1st floor, the resident exited the facility through the double doors to the left of the main entrance doors. The resident caught an MTA bus downtown, where the resident was found by police. Resident #7 returned to the secure unit in HH 5. The facility staff implemented 1:1 sitter for a week and then 1:1 rounding observation sitter for supervision, 7am and 7pm huddle meetings to inform staff of the elopement and increased supervision of the residents at risk for wandering/exit seeking. The staff member was educated to wait for the all unit doors to fully close behind them before walking away, staff continue to receive education on elopement risk resident and identifying exit seeking behaviors. After Resident #7's second elopement in June 2025, the facility decided to implement an alternative method of preventing elopement through acquiring the WanderGuard electronic monitoring system. On 9/15/2025, the facility started a rolling activation of the WanderGuard electronic monitoring system. Resident #7's unit, HH 5 was the first unit to be activated and wander/exit seeking residents received a wander guard electronic bracelet that communicates with exit sensors at the unit doors to alert staff if a resident at risk attempts to leave the secured area. By 9/29/2025, the entire facility was completed. During installation, a representative from the company educated staff on how the WanderGuard electronic system works. All facility residents were reassessed with the Wandering Risk Assessment to confirm who needed a wander guard electronic bracelet. HH 5 and HH 6 are secured units, and the majority of the wandering/exiting seeking residents reside on those units. There have been no other elopements from the facility. After surveyor review, interview, and observation and based on the above actions taken by the facility and verified by the surveyor on-site, it was determined that the facility had corrected the deficient practice by 6/17/2025, prior to the start of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview it was determined the facility failed to ensure safe storage of medications. This was evident during the surveyor's initial tour of the facility for 1 medication cart on 1 out of 10 nursing units during the facility's complaint survey. The findings include: During the survey team's initial tour of the facility on 11/13/25 at 7:49AM a medication cart was observed with the metal button protruding outward which indicated the cart was unlocked, and was unattended in the resident hallway. Upon further surveyor observation, all drawers of the cart, containing various medications, was able to be opened by the surveyor. Surveyors attempted to find facility staff to inform of the concern. Upon informing staff at the nurse's station, Registered Nurse (RN) #3 responded to the surveyor's concern. At this time surveyors conducted an interview and shared concerns with RN #3 who confirmed they were responsible for the medication cart. On 11/13/25 at 7:55AM the concern was shared by surveyors with the facility's Director of Nursing who acknowledged understanding of the concern. On 11/18/25 at 2:23PM the concern was shared with the facility Administrator.

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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** Based on record review and interview with staff, it was determined that the facility failed to maintain medical records in accordance with accepted professional standards and practices related to residents wander risk status and required assessments. This was evident for 2 (Resident #5 and Resident #7) out of 16 residents reviewed for wandering/elopement during the complaint survey.The findings include: 1. On 11/14/25 at 11:12 AM, review of the electronic medical record for Resident #5 documented a high wander risk score of 13 from an assessment completed 6/27/25; however, the resident was not included on the facility's wander list, and there was no quarterly assessment documented after 6/27/25. Review of Resident #5's care plan, documented on 4/3/25 and revised 5/1/25, noted wandering behaviors related to adjustment to the nursing home. The incomplete and inaccurate documentation failed to represent the resident's current risk status and need for monitoring. At 1:14 PM, the Director of Nursing and the administrator acknowledged that the quarterly wander assessment had been missed and that the resident's risk status was not reflected on the wander list. On 11/17/25 at 8:29 AM, further review confirmed the wander assessment was completed on 11/14/25, after surveyor intervention. 2. On 11/13/2025 at 10:00AM, during a review of Resident #7's electronic medical record, the Surveyor discovered a nursing progress note dated 1/23/2025 at 7:04PM which stated the resident was busy seeking exit and wanted to go to floor 2 and go home. On 11/13/2025 at 10:25AM, during a review of Facility Reported Incident #329725 and the facility's investigative file on, the Surveyor discovered that on 3/6/2025 at 3:04PM Resident #7 eloped. A review of Resident #7's Wandering Risk assessment dated [DATE] revealed an incomplete assessment with a score of 0. A review of Resident #7's readmission Wandering Risk assessment dated [DATE] revealed an incomplete assessment with a score of 0. Scores 0-8 indicate a low risk to wander. According to the Wandering Risk Assessment instructions, the assessment should be completed on admission and readmission, with a change of condition, and annually on all residents. On 11/13/2025 at 1:15PM, the Surveyor reviewed the Identifying Risk for Patient Wandering and Use of the WanderGuard System policy with an effective date of 11/13/2025. According to the policy, residents will be screened upon admission, whenever there is a change regarding wandering, and quarterly. The facility failed to complete an updated Wandering Risk Assessment that recognized Resident #7's exit seeking behaviors on 1/23/2025 and failed to complete an accurate Wandering Risk Assessment on 4/11/2025 that recognized the resident's elopement on 3/6/2025. During an interview with the Administrator and the Director of Nursing (DON) on 11/14/2025 at 1:30PM, the Surveyor was informed that all resident will be screened for wandering risk upon admission, quarterly, and as needed. The Surveyor expressed the concern with the accuracy and timeliness of the Wandering Risk Assessments.