Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215037	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keswick Multi-Care Center	700 West 40th Street Baltimore, MD 21211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47200 Based on record review and interview it was determined the facility failed to accurately address reporting timeframes for allegations of abuse in their facility policies. This was evident during the surveyor's review of a facility reported incident, MD#00188565 and has the potential to affect all residents. The findings include: On 10/7/24 at 8:45AM surveyors requested the facility's abuse prohibition policy and procedures from the facility's Administrator during the entrance conference, and the policies and procedures were provided shortly thereafter. On 10/8/24 at 11:46AM the surveyor began review of facility reported incident MD#00188565 which involved an allegation of abuse that had not been reported to the Office of Health Care Quality (OHCQ) within the required reporting timeframe. On 10/15/24 at 11:54AM the facility's Administrator was interviewed regarding abuse reporting time frames during the investigation of additional facility reported incidents (MD#00200867 and MD#00181354) which both included an allegation of abuse not reported to OHCQ within the required reporting timeframe. During the interview, the Administrator reported to the surveyor that because the allegation did not involve serious bodily injury, they did not have to submit the report within two hours, and further reported their expectation for any report of an allegation/incident of abuse that did not involve serious bodily injury was to be submitted within 24 hours to the state agency. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keswick Multi-Care Center	700 West 40th Street Baltimore, MD 21211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 10:32AM during continued review of the facility reported incident, the surveyor reviewed the two policies the facility had provided in response to the entrance conference documentation request on 10/7/24: 1) Abuse and Neglect policy (Policy #11637538), and 2) Abuse, Neglect, Exploitation, Misappropriation of Individual Property and any Reasonable Suspicion of a Crime Against an Individual or Participant policy (Policy #10959933). Review of policy #11637538 revealed the following information regarding abuse reporting: If there is an abuse allegation resulting in serious bodily injury, the individual shall report the suspicion immediately, regardless of time to the administrator or director of nursing, The facility will report the event to the Office of Health Care Quality (OHCQ) and the police no later than 2 hours after the event, If there is an allegation of abuse without serious bodily injury the facility will make an initial report to OHCQ within 24 hours of the event, The police department may be notified if indicated as directed by the administrator of director of nursing. Review of policy #10959933 revealed the following information regarding abuse reporting: Nursing Administration will notify the Department of Health and Mental Hygiene, Office of Health Care Quality and the ombudsman within 2 (serious bodily injury) to 24 hours of the report of alleged abuse depending on the seriousness of body injury, Abuse, neglect or a crime will be reported to the appropriate authorities as defined in this policy, Timing of Reporting requirements- if the events that caused the suspicion 1.) Result in serious bodily injury, the individual shall report the suspicion immediately, but no later than 2 hours after forming the suspicion, and 2.) Do not result in serious bodily injury, the individual shall report the suspicion no later than 24 hours after forming the suspicion, Policy shall be reviewed and updated for relevant lessons learned. On 10/16/24 at 12:09PM the surveyor conducted an interview with the facility's Administrator regarding their current understanding of abuse reporting. The Administrator reported to the surveyor that after the surveyor's interview with them on 10/15/24, regarding allegations of abuse, from what we are hearing now it usually gets reported immediately. After surveyor intervention, the Administrator reported that a plan was put into place to educate staff on reporting requirements. During the interview, the surveyor inquired as to how often the abuse policies were updated by the facility, to which the Administrator responded: Annually and and if any changes come up as needed, The policy is reviewed in QAPI (Quality Assurance and Performance Improvement). The surveyor inquired as to what actions had been taken by the facility in response to the current understanding of the reporting timeframes, and the surveyor noted the responses did not include any changes made to the abuse policies. At this time, the surveyor shared concerns regarding the abuse policies and the Administrator acknowledged and confirmed understanding of the concerns. On 10/17/24 at approximately 8:00AM surveyors were provided with the facility's updated abuse and neglect policy and copies of emails sent to facility staff regarding abuse reporting requirements and facility process, staff education being provided, and informing staff of the abuse policy update.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Keswick Multi-Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 West 40th Street Baltimore, MD 21211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50502 Based on observations, facility reports, record reviews, and interviews, it was determined that the facility staff failed to 1) report misappropriation of a residents' fund, and 2) report an allegation of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 4 (#75, #310, #69, #93) of 6 residents reviewed for abuse during a recertification/complaint survey. The findings include: 1) On 10/07/24 10:46 AM, Resident #75 was observed lying in bed with an elastic blue tie wrapped around his/her right arm with a key attached to it. Resident #75 stated that he/she used it for his/her locked drawer for his/her valuables. The surveyor asked Resident #75 about the missing money, he/she stated that last year his/her money went missing and could not remember the details. On 10/18/2024 at 10:43 AM, a review of MD00197124 and facility investigation documentation indicated that Resident #75 reported to the facility on [DATE] that he/she was missing $200.00 from his wallet. He/she had just returned from a hospital visit on 9/17/23. Resident #75 could not remember if his/her wallet was in his/her pocket during the overnight stay. Further review of the investigation revealed that the facility reported the incident to the Office of Health Care Quality (OHCQ) on 9/18/23 and submitted the final report on 9/22/23. The facility also conducted room search, staff and resident interviews and took measures to prevent further incident of similar nature by reminding Resident #75 to keep valuables inside the locked drawer and his/her safe. However, the facility failed to report the incident to the local law enforcement. On 10/18/2024 at 12:05 PM, during an interview with the Director of Nursing (DON), she stated that when residents' money or belongings were missing, the facility conducted staff interviews, searched the nearby areas and started investigating. She added, What was lacking when we investigated Resident #75's incident was, we should have notified the police after the incident. The DON was made aware that the failure to notify the law enforcement was a concern. 47200 2) On 10/8/24 at 11:46AM the surveyor conducted a review of the facility's investigation file for the facility reported incident MD#00188565. During this review, it was noted that Resident #310 reported an allegation of abuse on 2/1/2023 to dialysis staff who then reported the allegation via email to the facility's Director of Nursing (DON), Assistant Director of Nursing (ADON), and the [NAME] President of Clinical Services on 2/1/2023 at 2:34PM. Review of the email response to the dialysis staff from the [NAME] President of Clinical Services revealed the facility was aware of the allegation on 2/1/23 at 2:38PM. Review of the self-report form within the facility's investigation file documented that local law enforcement had been contacted on 2/1/23 at approximately 3:30PM and the date and time of the initial self-report to the Office of Health Care Quality (OHCQ) was documented as 2/2/23 at 5:00PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Keswick Multi-Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 West 40th Street Baltimore, MD 21211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 10:30AM the surveyor requested from the Administrator, the facility reported incident investigation file for further review. On 10/16/24 at 10:32AM upon receipt of the investigation file, the Administrator confirmed with the surveyor that this was the facility's complete investigation file. At this time, the surveyor shared concerns with the Administrator who acknowledged and confirmed understanding of the concerns. On 10/16/24 at 10:50AM the surveyor requested documentation of when the initial self-report for MD#00188565 was made to OHCQ. Shortly thereafter, documentation of the submitted report via email was provided that the initial self-report was submitted to OHCQ on 2/2/23 at 6:06PM, more than 27 hours after the facility became aware of the allegation of abuse. On 10/16/24 at 2:54PM the facility's ADON requested to speak with the surveyor, and at this time, the surveyor conducted an interview. During the interview, the ADON reported to the surveyor that at the time of the allegation, the facility was reporting to OHCQ according to what their understanding was of the reporting timeframe, which was 24 hours. They further confirmed with the surveyor that the facility was currently in servicing staff on the reporting of all allegations of abuse to now be made to OHCQ within 2 hours. 42507 3) On 10/11/2024 at 1:19 PM, review of the investigation report of Facility Reported Incident (FRI), MD00200867, revealed that Resident #69 reported to a family member on 12/20/2023 that a staff member pushed his/her leg. Further review of the investigation report of the FRI revealed that the facility reported the allegation of abuse to the Baltimore City Police Department on 12/20/2023. However, the initial self-report of the allegation of abuse was submitted to the State Survey Agency (OHCQ) and LTC Ombudsman on 12/21/2023, more than 2 hours past the time the facility staff were made aware of the allegation. Thus, failing to meet the 2-hours reporting requirements for any allegation of abuse. On 10/15/2024 at 11:54 AM in an interview with the Nursing Home Administrator (NHA), the Surveyor reviewed the above FRI with her. DON was informed of surveyor's concerns regarding the actual date of the above incident (12/20/2023) and the date/time the initial report was sent to OHCQ (12/21/2023). NHA reviewed and confirmed that the initial report of the above allegation of abuse was submitted to OHCQ on 12/21/2023 at 5:15 PM. NHA stated that the allegation did not involve serious bodily injury, so she did not have to submit the initial report within 2 hours. She stated that the expectation was for any report of an allegation/incident of abuse that did not involve serious bodily injury to be submitted within 24 hours to the State Agency. 4). On 10/15/2024 at 11:00 AM, a review of Facility Reported Incident (FRI), MD00181354, revealed that Geriatric Nursing Assistant (GNA #38) reported to the House Supervisor on 7/24/2022 that Resident #93 did not want GNA #38 to care for him/her any longer. Per the report, the House Supervisor interviewed Resident #93 who stated that GNA #38 was rough with him/her. On 10/15/2024 at 11:10 AM, a review of the initial self-report revealed it was sent to the State Agency (OHCQ) on 7/25/2022 at 5:17 PM. Thus, failing to meet the 2-hour reporting requirements for any allegation of abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Keswick Multi-Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 West 40th Street Baltimore, MD 21211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/2024 at 11:58 AM, an interview was conducted with the Nursing Home Administrator (NHA): She reviewed and confirmed that the initial self-report of the above allegation of abuse was submitted to OHCQ on 7/25/2022 at 5:17 PM. NHA stated that the allegation did not involve serious bodily injury, so she did not have to submit the initial report within 2 hours (reason why it was reported to the State Survey Agency within 24 hours). The surveyor reviewed the tag (F609) guidance for reporting allegations of abuse with the NHA, and she stated that she was going to follow up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER: Keswick Multi-Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 West 40th Street Baltimore, MD 21211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47200 Based on review of a facility reported incident (MD #188565), record review and staff interviews it was determined the facility failed to take measures to protect the resident during an abuse investigation. This was evident for 1 (Resident #310) out of 6 residents reviewed for abuse during the facility's recertification survey. The findings include: On 10/8/24 at 11:46AM the surveyor conducted a review of the facility's investigation file for the facility reported incident MD#188565. During this review, it was noted that Resident #310 reported an allegation of abuse on 2/1/2023 to dialysis staff who then reported the allegation via email to the facility's Director of Nursing (DON), Assistant Director of Nursing (ADON), and the [NAME] President of Clinical Services on 2/1/2023 at 2:34PM. Review of the email response to the dialysis staff from the [NAME] President of Clinical Services revealed the facility was aware of the allegation on 2/1/23 at 2:38PM. Documentation of the allegation reported to the facility included the alleged abuse occurred for the past two nights On 10/16/24 at 10:30AM the surveyor requested from the Administrator, the facility reported incident investigation file for further review. On 10/16/24 at 10:32AM upon receipt of the investigation file, the Administrator confirmed with the surveyor that this was the facility's complete investigation file. Review of the investigative file on 10/16/24 at 10:37AM revealed a written statement signed by Registered Nurse (RN) #34 dated 2/1/23 at 2:53PM which documented Resident #310's report of an allegation of abuse to them that the resident reported had occurred two nights in a row in which there was a male perpetrator. RN #34 further documented in their written statement, the resident's expression of fear for telling staff, and fear for their safety. Review of the facility's final self-report indicated two males were working during the alleged timeframe. No information in the investigative file could be found that any action/precaution was taken to protect the resident from any male staff during the course of the investigation. On 10/16/24 at 10:50AM the surveyor requested from Executive Assistant #35, the names and employee files for the two male staff identified as working on the same unit as the resident during the alleged timeframe. When the surveyor inquired as to who the two male staff identified were, their response was: but this was hallucinations. At this time, the surveyor shared concerns. Review of the investigative file on 10/16/24 at 1:44PM revealed the following information: 1.) the two identified male staff from the investigation were documented on staff assignment sheets as having continued to work shifts while the investigation was in process, after the allegation was made by the resident, during the course of the investigation, and prior to being interviewed and giving statements, 2.) review of employee timesheet documentation revealed both male staff members were documented as having worked the 3-11pm shift on 2/1/23, and 3.) the psych consult for the resident was noted by the surveyor to be documented as having occurred on 2/2/23. (continued on next page)

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Keswick Multi-Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 West 40th Street Baltimore, MD 21211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 2:54PM the facility's Assistant Director of Nursing (ADON) requested to speak with the surveyor, and at this time, the surveyor conducted an interview. During the interview they confirmed with the surveyor that no staff had been removed from assignment or placed on administrative leave, but going forward the facility will do so. At this time, the surveyor shared their concerns with the ADON who acknowledged and confirmed understanding of the concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Keswick Multi-Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 West 40th Street Baltimore, MD 21211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47200 Based on observation, interview, and record review it was determined that the facility failed to develop, initiate, and ensure a care plan for a resident was comprehensive and person centered. This was evident for 3 (#50, # 312, #12) of 58 residents reviewed during a recertification/complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) On 10/7/24 at 8:35AM, during the surveyor's initial tour, Resident #50 was observed in bed with two lower extremity prosthesis present on the floor within their room. On 10/8/24 at approximately 8:55AM the surveyor observed Resident #50 wearing their prosthesis. On 10/9/24 at 8:59AM the surveyor reviewed the medical record which revealed the following medical order for therapy that included prosthetic training: recertification for 9/26: PT to continue PT treatment x 2 visits/week x 30 days for therapeutic exercise, therapeutic activity, neuromuscular education, gait training, prosthetic training, wc mobility/management, pt/CG education. No active medical order for use of the prosthetics was observed to be in place. On 10/9/24 at 9:10AM further surveyor review of the medical record revealed the resident's care plan did not include their lower extremity prosthesis. Review of the resident's medical diagnoses revealed the following: 1.) acquired absence of right leg below the knee, and 2.) acquired absence of left leg below the knee. The surveyor noted the following care plan interventions were in place for the resident: Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails, and Educate the resident on the importance of proper foot care including; proper fitting shoes, wash and dry feet thoroughly, keep toenails cut, inspect feet daily, daily change of hosiery and socks. On 10/9/24 at 9:36AM the surveyor conducted an interview with Registered Nurse (RN) #28 who reported they were familiar with Resident #50 and confirmed the resident was using their prosthesis every day. At this time, the surveyor inquired to RN #28 as to if a medical order or care plan was in place for the use of the prosthesis. RN #28 observed and reviewed the medical orders and care plan for the resident and confirmed with the surveyor that they did not see any medical orders or care planning present for the resident's prosthesis, and at this time, the surveyor shared their concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Keswick Multi-Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 West 40th Street Baltimore, MD 21211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 9:47 AM the surveyor conducted an interview with Unit Manager #29 who reviewed the resident's medical record and confirmed with the surveyor that there was no medical order or care planning for the use of the prosthesis. At this time, Unit Manager #29 stated the following to the surveyor: I don't see orders in there, I can definitely put those in and care-plan it. Unit Manager #29 confirmed with the surveyor that Resident #50 was currently using the prosthesis and their expectation was for there to be a medical order and care planning in place. At this time, the surveyor shared their concerns with Unit Manager #29 who acknowledged and confirmed understanding of the concerns. 50502 2) On 10/07/24 at 11:07 AM, Resident #12 was observed with no upper or lower teeth. The surveyor asked if he/she was wearing dentures, he/she stated yes and that the bottom dentures were in the bathroom, and he/she showed the surveyor that the upper dentures were kept in a container on the bedside table. On 10/08/24 at 12:14 PM, Resident #12 showed the surveyor that he/she was wearing the upper dentures. He/she stated that he/she had not worn the lower dentures because they didn't fit him/her, he/she added that the facility was aware, but the insurance won't pay for a replacement of the ill-fitting bottom dentures. The surveyor observed that the bottom dentures were placed on the bathroom sink, inside a blue denture cup. On 10/10/24 at 08:29 AM, a record review revealed that Resident #12 had the following dental consultations that confirmed the presence of dentures: -1/21/21, full upper and lower dentures were present -2/4/21, full upper dentures were present -3/26/21, full upper dentures were present -4/29/21, full upper dentures were present -3/14/24, the resident refused to be seen by the dentist On 10/10/24 at 08:35 AM, a review of the care plan revealed no pertinent goals and interventions related to denture use were initiated on admission. On 10/10/24 09:27 AM, in an interview with Geriatric Nurse Assistant (GNA #10), he/she stated that when a resident wore dentures, the GNAs clean them and put them inside the resident's mouth in the morning and removed them at night. He/she added that one resident, Resident #12, did it for herself and that if he/she needed help, assistance was provided by the staff. On 10/10/24 at 9:20 AM, an interview with Licensed Practical Nurse (LPN #8) revealed that the nurses completed the oral assessments on admission and documented the findings in the admission packet under assessments, clinical admission. On 10/10/24 at 11:10 AM, a review of the admission assessment dated [DATE] revealed that Resident #12 Has own teeth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215037	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keswick Multi-Care Center	700 West 40th Street Baltimore, MD 21211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 11:12 AM, a review of the baseline care plan dated 11/19/2023 under Dietary: Dental Prosthetics also revealed natural teeth. On 10/10/24 at 11:54 AM, an interview with the Unit Manager (UM #9) revealed that during a resident's admission, a head-to-toe assessment was completed by the admitting nurse in the electronic health record and the nurse initiated the care plan and that he followed up on what items were missing. He further stated that if the resident had missing teeth and refused to wear dentures, the nurses were expected to document the missing teeth and the refusals in the progress notes. UM #9 added that he developed and updated the care plans as needed. UM #9 was made aware that the denture care plan was not developed since Resident #12's admission. On 10/10/24 at 12:15 PM, a review of Resident #12's Treatment Administration Report (TAR) revealed no orders were placed related to denture care and storage. On 10/11/24 at 8:37 AM, a record review revealed that a new Impaired Dentition care plan for Resident #12 was added on 10/10/24 after surveyor intervention. On 10/17/24 at 02:10 PM, the DON and the Assistant Director of Nursing (ADON) were made aware that Resident #12's denture care plan was not developed since admission, and they were in agreement. 42507 3) Hemodialysis (HD) or simply dialysis is a process of filtering the blood of a person whose kidneys are not working normally. An arteriovenous (AV) fistula is a connection that's made between an artery and a vein for dialysis access. A surgical procedure, done in the operating room, is required to stitch together two vessels to create an AV fistula. The MDS (Minimum Data Set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. On 10/18/2024 at 1:05 PM, a review of Resident #312's clinical records revealed the resident was admitted to the facility in November 2023 and discharged in January 2024 with medical diagnoses that included but not limited to End Stage Renal Disease (ESRD) and dependence on Renal Dialysis. Review of Modification of Admission/Medicare 5-day MDS with Assessment Reference Date (ARD) of 11/12/2023 captured ESRD under section I (Active diagnoses) and Hemodialysis captured under section O (Special treatments, procedures, programs). On 10/18/2024 at 2:05 PM, Review of physician orders revealed the following orders with start date of 11/8/2023: - Hemodialysis 3 times per week on M W F, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keswick Multi-Care Center	700 West 40th Street Baltimore, MD 21211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor fistula/graft on Left upper arm for infection, ulceration, bleeding, thrombosis formation(bruit/thrill) - Avoid tourniquets, procedures, BP cuffs, tight clothing/jewelry to LUE (left upper extremity) with fistula/graft On 10/21/2024 at 8:48 AM, a review of nurses' progress notes revealed the following clinical admission evaluation documentation dated 11/8/2023 at 19:33 (7:33 PM): .[resident's name] is admitted to room . from [name of acute care facility] . Discharge Diagnosis: .5) End stage renal disease Left upper arm AV fistula no bleeding noted resident is a dialysis and stated s/he was dialyzed today. On 10/21/2024 at 9:11 AM, further review of Resident #312's medical record revealed the facility staff failed to develop and implement a care plan with specific interventions and approaches to address the resident's ESRD and hemodialysis. The care plan was not comprehensive, and resident centered. On 10/21/2024 at 2:05 PM, in an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the surveyor shared concerns regarding failure to develop a care plan for the diagnosis of ESRD and hemodialysis. ADON stated that the expectation was that the care plan should address hemodialysis for a resident that was on it. Both DON and ADON reviewed the resident's care plan and confirmed that it failed to address ESRD and hemodialysis with goals and interventions. ADON stated that the Unit Manager should have captured on the care plan ESRD/hemodialysis as a stand-alone problem with goals and interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Keswick Multi-Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 West 40th Street Baltimore, MD 21211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 45131 Based on residents' representative interviews, resident record reviews, and staff interviews, it was determined that the facility failed to implement an interdisciplinary care plan with effective interventions to prevent the repeated removal of gastronomy tubes. This was evident for one (Resident #68) of 58 residents reviewed for care plans during the recertification/complaint survey process. Findings Include: A gastronomy tube (g-tube) is inserted through the abdomen's wall into the stomach. The g-tube allows air and fluid to leave the stomach and can be used to give medication and fluids to the resident. On 10/8/2024 at 11:51 AM, an interview with Resident #68's representative revealed that the resident had 5 incidents that required multiple g-tube replacements within an approximate 5-month period. On 10/9/2024 at 10:52 AM, a review of Resident #68's record revealed that the resident was admitted to the facility in December 2019, and the resident's g-tube was placed before admission. A review of the change in condition assessment forms revealed that the resident had multiple incidents of g-tube removal. It was noted that between June 2024 and October 2024, the resident had 5 separate incidents of pulling out the g-tube, which subsequently required g-tube replacement. On 10/9/2024 at 11:00 AM, a review of Resident #68's care plan revealed that in May 2022, the resident's care plan stated, The resident will have fewer episodes of g-tube removal. The surveyor noted that the resident's care plan was revised in August 2024; however, no additional effective intervention was added to the care plan to prevent the resident from pulling out the g-tube. On 10/10/2024 at 09:06 AM, in an interview with a registered nurse (RN #22), she stated that Resident #68 had an order for an abdominal binder to prevent the resident from removing the g-tube. When asked by the surveyor if any additional measures could be put in place to prevent or reduce the frequency of the g-tube removal, RN#22 stated that there was nothing else they could do. Upon further investigation, RN #22 revealed that any nurse can initiate or update the care plan; however, the unit manager primarily manages residents' care plans. On 10/10/2024 at 12:09 PM, an interview with the unit manager (RN #9) revealed that RN #9 was aware of Resident #68's g-tube removal episodes. RN#9 acknowledged that the care plan updates were a part of their responsibility. RN #9 acknowledged that the care plan was ineffective and stated that the care plan would be updated to address the resident's needs. On 10/21/2024 at 11:45 AM, the surveyor reviewed the findings with the Director of Nursing (DON), and she acknowledged the above-mentioned findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keswick Multi-Care Center	700 West 40th Street Baltimore, MD 21211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 44441 Based on a complaint incident MD00209605, record review and staff interviews, it was determined that the facility failed to provide Activities of Daily Living (ADL) care for a dependent resident. This was evident for 1 (resident #66) of 4 residents reviewed for ADL care during the recertification/complaint survey. The findings include: On 10/08/24 at 8:17 AM review of a complaint incident MD00209605 sent in by resident's family reported that resident #66 has been in the facility for over 45 days and never received a full shower/Bathing. Review of the Physicians order on 10/10/24 at 11:43 AM had an order dated 7/11/24 that read: Skin Assessment: Bath Days on Monday and Thursday every evening shift. Review of the MDS with an Assessment Reference Date (ARD) of 7/15/24 revealed that resident #66 was coded as depended for showers and baths. Review of the GNA task sheet from July to October 2024 revealed that resident #66 did not get a shower on the assigned shower days, only bed baths. In an interview with staff #24 a Geriatric Nursing Assistant (GNA) on 10/11/24 at 9:51 AM, she was asked how shower days are scheduled for residents and she said they are scheduled 2x a week for all residents and are documented when given, in the GNA task sheet in the electronic record. The GNA task sheet was reviewed with staff #24 and the Assistant Director of Nursing (ADON) and revealed that resident never got a shower from July through October 2024, he/she only got bed baths. The GNA (staff #24) was asked to explain, and stated that Resident #66's shower days were scheduled on Monday's and Friday's which coincides with the resident's dialysis days. He/she explained that night shift staff are responsible for getting Resident #66 ready to go for dialysis before day shift arrives and that Night shift does not give showers. On 10/11/24 at 10:05 AM, the ADON was made aware that this was a concern, he/she confirmed that the resident never got showers since admission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Keswick Multi-Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 West 40th Street Baltimore, MD 21211	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49409 Based on the review of residents' medical records and interviews with facility staff, it was determined that the facility failed to ensure that the resident received treatment and care in accordance with professional standards of practice. This was evident for one (Resident #165) out of one resident who was reviewed for quality of care/ treatment in accordance with professional standards of practice during the recertification/complaint survey. The findings include: STAT means right now. The term STAT is usually used in medical orders. STAT term derived from the Latin word Statim, which translates to immediately, and denotes that medical order should be prioritized. A medical record review on 10/08/24 at 03:04 PM revealed that resident #165 sustained a fall on 09/03/23 around 8 PM, and the resident complained of a sharp radiating pain in the left leg, a pain level of 9/10. After pain progressively increased, on 09/04/2023 at 00:40, health status notes by Registered Nurse # 43 indicated that Resident #165 complained of 10/10 left leg pain. Resident #165 stated: It hurts right on the outside . it's bad. A review of the Nurses' progress notes and medication administration record (MAR) revealed that the facility staff failed to administer pain medication until 09/03/23 at 10:30 PM when the resident complained of a pain level of 9/10 after the fall occurred around 8 PM. A STAT X-ray of Left Hip 2-Views was ordered after the resident sustained a fall on 09/03/23 at 8 PM. The X-ray technician did not come to the facility until the next day, 09/04/23, at 10:30 AM. Despite the Physician's order on 09/03/23 at 8:59 PM to send the resident out to the Hospital, the facility staff delayed sending the resident to the Hospital. An interview with Registered Nurse # 41 on 10/16/24 at 10:25 AM revealed that for any acute pain after the fall, based on my clinical judgment, I would rather send the resident to the hospital for evaluation. X-Ray company will not give their expected time of arrival, and we had issues with them in the past, and waiting for them potentially makes the issue worse. On 10/16/24 at 10:52 AM, the Surveyor validated with the ADON and the Director of Nursing (DON) regarding the delay in pain medication administration and the delay in sending the resident to the Hospital for evaluation despite the provider's order to send resident #165 to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keswick Multi-Care Center	700 West 40th Street Baltimore, MD 21211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44441 Based on a complaint investigation, record review and staff interviews, it was determined that the facility failed to order appropriate intervention and treatments for the maintenance of a Urostomy. This was evident for 1 (Resident #164) of 1 resident reviewed for urostomy during the recertification/complaint survey. The findings Include: A urostomy is an opening in the belly made during surgery to redirect urine away from a bladder that's not working as it should. A special bag called urostomy bags are used to collect urine from the urostomy. On 10/15/24 at 9:38 AM, review of a complaint incident MD00194576 revealed that Resident #164, who had a urostomy, complained that her urine bag was leaking near the surgical wound and that the bag was left full of waste from 5:30 AM to 10:30 AM. Further, the urine bag leaked everywhere when the resident attempted to walk and that this had happened more than once. Review of the resident's record on 10/15/24 at 9:42 AM revealed that this resident was admitted to the facility on [DATE] with a urostomy. However, further review of the admission orders or subsequent orders did not include an order for urostomy care such as stoma care, site assessment, emptying of the urostomy bag, documentation of the urine output or nursing interventions for the urostomy care and management. The Director of Nursing (DON) in an interview on 10/15/24 at 11:15 AM was asked the process for care and management of residents with urostomies. He/she stated that these residents always have orders that specify the type and location of the urostomy and nursing orders to assess and monitor the urostomy site. The DON was asked how the nursing staff are made aware that a resident had a urostomy. He/she explained that an order would be in POINT CLICK CARE (PCC -the electronic record used by the facility for documentation) placed by the admission nurse after reviewing the hospital discharge summary. The DON was asked the expectation from staff regarding urostomy care. He/she stated that staff are expected to assess the skin around the area for redness, monitor urine drainage amount, assess urine color, pain at site, drainage bag and leakages. On 10/15/24 at 11:20PM The DON was made aware that resident #164 did not have orders to assess and monitor the urostomy including emptying the urostomy bag and that this was a concern. He/she confirmed that there were no orders.