

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 05/12/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview, record review, facility document, and facility policy review, the facility failed to protect a resident from verbal abuse for 1 (Resident #6) of 8 residents reviewed for abuse.</p> <p>Findings included:</p> <p>A facility policy titled, Prevention and Reporting of Abuse and Neglect, revised 10/2024, indicated, [Facility Name] has a zero tolerance for resident/patient abuse and neglect in any of it's [sic] forms.</p> <p>An admission Record indicated the facility admitted Resident #6 on 03/15/2022. According to the admission Record, the resident had a medical history that included diagnoses of cerebrovascular disease, depression, dementia, and chronic kidney disease.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/28/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated Resident #6 felt down, depressed, or hopeless, seven to eleven days during the assessment's lookback period. The MDS revealed the resident felt tired or had little energy for two to six days and felt bad about themselves never or one day during the assessment's lookback period. The MDS indicated Resident #6 was dependent on staff for toileting hygiene and was always incontinent of bowel and bladder.</p> <p>An annual MDS, with an ARD of 01/25/2025, revealed Resident #6 had a BIMS score of 13, which indicated the resident had intact cognition. The MDS indicated Resident #6 felt down, depressed, or hopeless, seven to eleven days during the assessment's lookback period. The MDS revealed the resident felt tired or had little energy for two to six days and felt bad about themselves never or one day during the assessment's lookback period. The MDS indicated Resident #6 was dependent on staff for toileting hygiene and was always incontinent of bowel and bladder.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #6's Care Plan Report, included a problem statement revised 10/18/2024, that indicated the resident had an activities of daily living (ADL) self-care performance deficit related to their disease process, cerebrovascular accident with left sided weakness, and status post spinal surgery. Interventions directed staff that the resident was dependent on one staff for incontinence care as needed (initiated 10/18/2024 and revised 01/15/2025). The Care Plan Report included a problem statement revised on 07/13/2022, that indicated the resident had a behavior (crying) related to a history of major depression, anxiety, and facility admission. Interventions (initiated 01/15/2025) directed staff to administer medications as ordered, provide opportunities for positive interaction and attention, and monitor behavior episodes.</p> <p>A Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form, dated 12/19/2024, revealed Resident #6's family member informed Social Worker (SW) #1 that they were on the telephone with Resident #6 on 12/17/2024, when a Geriatric Nursing Assistant (GNA) was providing incontinence care to Resident #6. The report revealed the family member overheard the GNA say to Resident #6, Did you just [expletive] on me, and Resident #6 began to apologize and cry. The report revealed the alleged perpetrator was GNA #25.</p> <p>A document titled, Staff Interview, dated 12/19/2024, revealed Nursing Supervisor #13 and the Assistant Director of Nursing (ADON) conducted an interview by telephone with GNA #25. The Staff Interview revealed GNA #25 was assigned to Resident #6 and provided a bed bath and incontinence care. The Staff Interview revealed GNA #25 stated the resident always had incontinence episodes. Per the Staff Interview, GNA #25 indicated there was no problem providing care, noting Resident #6 cried every single day. The Staff Interview also indicated GNA #25 said they did not use inappropriate language with the resident while providing care; however, told the resident to stop pushing it out while I'm back here.</p> <p>A typed document titled, [Resident #6] complaint reported by [name of family member] 12/19/2024 12:30, signed by SW #1, indicated Resident #6's family member reported that on 12/17/2024 the GNA caring for Resident #6 was verbally inappropriate when changing the resident. Per the document, the family member stated they overheard the GNA ask Resident #6 why [the resident] was [expletive] on her. The document revealed that the family member reported Resident #6 was apologizing because they had no control over their bowels and that the resident was embarrassed, noting if the resident could get up and use the bathroom, they would. Further review revealed SW #1 interviewed Resident #6. Per the document, Resident #6 reported that while being changed by GNA #25, they were asked to turn onto their side. The document indicated Resident #6 stated when they began turning, their bowels began eliminating, and GNA #25 told them to stop pushing. The document revealed Resident #6 tried to explain that they were not pushing and then GNA #25 asked Resident #6 why are you pushing your [expletive] on me? According to the document, Resident #6 said they were embarrassed, upset, and cried during the interaction because they had no control over their bowels. The document further revealed Resident #6 stated GNA #25 used other expletives when performing tasks in their room, not speaking directly to them, but just when performing tasks in the room. Per the document, Resident #6 said they felt safe in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A BH [behavioral health] Psychotherapy Progress Note, dated 12/27/2024 and signed by the Psychotherapist, indicated Resident #6 was seen related to their history of depression, with loneliness and crying spells. According to the note, the resident spoke about their incontinence and how that led to an upsetting experience with a staff member. The note indicated the resident had a negative interaction with staff that was addressed by administration to ensure that it would not happen again. The note indicated Resident #6 was focused on their bowels and that the physician spoke with the resident regarding their concern of their bowel function.</p> <p>A BH Follow Up Progress Note, dated 12/31/2024, indicated Resident #6 was seen at the request of the social worker for allegations of verbal abuse. The note indicated Resident #6 revealed that while being provided incontinence care, a GNA told them to stop squeezing (referring to the resident forcing a bowel movement) before the resident got [expletive] all over her (the GNA). Per the note, the resident replied to the GNA that they were not trying to have a bowel movement but could not control themselves, due to a medical condition. The note further indicated Resident #6 stated the GNA continued to curse under their breath while getting the resident out of bed.</p> <p>During a concurrent observation and interview on 05/06/2025 at 12:15 PM, Resident #6 was up in the dining room for lunch, and dressed appropriately. Resident #6 stated they did not recall the incident with the GNA, but if they had issues, they knew who to speak with. Resident #6 stated they could not remember any staff speaking inappropriately.</p> <p>During a telephone interview on 05/09/2025 at 11:10 AM, GNA #25 stated nothing happened when asked about the incident. GNA #25 stated Resident #6 was having a bowel movement, and she told the resident that she would put the brief back on them until the resident was finished, because she could not keep holding the bowel movement and clean the resident. GNA #25 stated the resident kept pushing. GNA #25 then stated she told Resident #6 to call her when they were done. She stated she never used inappropriate language.</p> <p>During an interview on 05/09/2024 at 3:24 PM, SW #1 stated she talked with Resident #6 and the resident's family member. She stated the resident's family member informed her a GNA used inappropriate language. Per SW #1, Resident #6 confirmed GNA #25 used inappropriate language. She stated Resident #6 was frequently tearful, as this was not new behavior, but the resident's coping mechanism. SW #1 said GNA #25 was terminated.</p> <p>During an interview on 05/09/2025 at 3:35 PM, the Psychotherapist stated Resident #6 was at their baseline following the incident, and the incident did not trigger the resident. He stated the resident's coping mechanisms were expanding, and he was seeing the resident out on the unit more. He stated the incident did not set the resident back.</p> <p>During an interview on 05/08/2025 at 3:12 PM, the Executive Director (ED) stated abuse of any kind would not be tolerated in the facility. The ED stated the allegation of abuse for Resident #6 was substantiated by the facility and GNA #25 was terminated.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview, record review, facility document and policy review, the facility failed to report an injury of unknown source within two hours of being informed that the resident sustained a serious bodily injury for 1 (Resident #1) of 8 residents reviewed for abuse.</p> <p>Findings included:</p> <p>A facility policy titled, Prevention and Reporting of Abuse and Neglect, revised 10/2024, indicated, [Facility Name] has a zero tolerance for resident/patient abuse and neglect in any of it's [sic] forms. The policy revealed, 3. Abuse Reporting a. The facility will report allegations of abuse, neglect, exploitation, or mistreatment, misappropriation of resident property, as well as injury of unknown origin, in accordance with regulatory reporting guidelines: i. abuse and serious bodily injury within 2 hours to state agencies, unless; ii. the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury; which will be reported no later than 24 hours.* iii. The police department (911) will be notified of all allegations of abuse.</p> <p>An admission Record indicated the facility admitted Resident #1 on 06/13/2024. According to the admission Record, the resident had a medical history that included diagnoses of osteoarthritis, age-related osteoporosis without current pathological fracture, and unspecified dementia. The admission Record revealed a principal diagnosis of unspecified fracture of the upper end of the left humerus with routine healing, with an onset date of 04/22/2025.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/18/2025, revealed Resident #1 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS indicated the resident had no functional limitation in their range of motion of the upper and lower extremities. The MDS revealed Resident #1 was dependent on staff for rolling from their back to the left and right sides, moving from sitting on the side of the bed to lying flat, moving from lying on their back to sitting on the side of the bed, standing from a sitting position, and chair/bed-to-chair transfers. The MDS specified Resident #1 had no falls since admission, entry, re-entry, or the prior assessment.</p> <p>Resident #1's Care Plan Report, included a problem statement initiated 06/14/2024, that indicated the resident had an activities of daily living (ADL) self-care performance deficit related to activity intolerance, dementia, impaired balance, and multiple comorbidities affecting their body system. Interventions directed staff to use bilateral quarter side rails as an enabler for safety during care (initiated 06/14/2024).</p> <p>Resident #1's SBAR [Situation, Background, Appearance, Review and Notify] Communication Form, dated 04/21/2025, indicated Resident #1 had a change in condition related to left shoulder swelling and pain. The SBAR Communication Form revealed the resident had new onset pain, evidenced by occasional moaning or groaning and facial grimacing. The form indicated the physician was notified on 04/21/2025 at 1:00 PM and ordered a 2-view left shoulder x-ray, pain medication, and warm compresses every four hours as needed.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1's Radiology Results Report, dated 04/21/2025, revealed there was a minimally angulated fracture of the proximal neck of the left humerus and degenerative changes throughout the left shoulder. The report indicated that it was difficult to determine if the fracture was related to trauma or if it was a pathological fracture. The report contained a recommendation from the radiologist for the resident to have a follow up computed tomography (CT) scan of the proximal left humerus and scapula for further characterization of the fracture. The report revealed a Reported Date of 04/21/2025 at 5:58 PM, and a handwritten notation on the document that indicated the physician was aware.</p> <p>A Maryland Department of Health Office of Health Care Quality Facility Reported Incident Initial Report Form, dated 04/21/2025, indicated the facility became aware of the incident on 04/21/2025 at 9:00 PM and notified the state survey agency of Resident #1's injury of unknown source on 04/21/2025 at 10:45 PM.</p> <p>An e-mail titled, Confirmation - Abuse Report, dated 04/21/2025 at 11:04 PM, validated transmission of the facility's report of abuse.</p> <p>During an interview on 05/07/2025 at 3:30 PM, Licensed Practical Nurse (LPN) #5 stated when the facility received Resident #1's x-ray results, she sent the report to the physician via a secure portal and noted on the document that the physician was aware because she sent the results. LPN #5 stated she did not write the time on the report when she sent it to the physician.</p> <p>During a follow-up telephone interview on 05/12/2025 at 2:10 PM, LPN #5 clarified that she sent Resident #1's x-ray result to the physician between 6:30 PM and 7:00 PM, and the physician called at about 9:30 PM to give an order to send the resident to the hospital. LPN #5 stated she then notified the nursing supervisor.</p> <p>The Executive Director (ED) was interviewed on 05/08/2025 at 3:40 PM. The ED stated an LPN notified the supervisor of Resident #1's swollen shoulder, but the supervisor never completed the initial 2-hour report. The ED stated she believed a 2-hour report should have been completed within two hours of 6:00 PM, when the facility received the x-ray result that showed resident #1 had a fracture, but not earlier because the facility was waiting for the x-ray results.</p>		