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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47200 Based on observation, interview, and record review it was determined the facility failed to ensure a resident's call device was accessible to the resident. This was evident for 1 (#145) out of 2 residents reviewed for call device functioning during the facility's recertification survey. The findings include: On 10/7/24 at 8:58AM, during the surveyor's initial tour of the facility, Resident #145 was observed sitting on the side of their bed with their call device attached to the side rail of the bed, which was in the down position. The resident's call device was observed resting on the floor underneath their bed. The surveyor observed the bedside table situated between the resident and where the call bell was laying on the floor. At this time, the resident was observed to be unable to reach their call device. On 10/7/24 at 9:01AM surveyors conducted a dual observation with Licensed Practical Nurse (LPN) #27 to observe the concern. At this time, upon surveyor's sharing of the concern, LPN #27 observed the resident did not have their call device within reach and proceeded to pick the call device off of the floor and clip it to the resident's bed within their reach. At this time the surveyor conducted an interview with LPN #27 who confirmed with the surveyor that the call device was expected to be within reach of the resident, and confirmed with surveyors that when staff leave the room they have to make sure the call device is clipped so that it is not dangling. At this time, LPN #27 acknowledged and confirmed understanding of the concern. On 10/22/24 at 11:53AM the surveyor reviewed the medical record for Resident #145 which revealed the following care plan intervention: be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; the resident needs prompt response to all requests for assistance.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. 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. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50502 Based on record review and interview, it was determined that the facility failed to transmit Minimum Data Set (MDS) assessments within 14 days of completion and create a discharge assessment. This was evident for 3 (Residents #64, #146 and #148) of 3 residents reviewed for resident assessments during the recertification/complaint survey. The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. Nursing homes are required to submit the Omnibus Budget Reconciliation Act (OBRA) required MDS records for all residents in Medicare or Medicaid certified beds regardless of the payer source to Centers for Medicare and Medicaid Services (CMS') Internet Quality Improvement and Evaluation System (iQIES). Skilled nursing facilities (SNFs) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS). Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. On 10/15/24 at 10:49 AM, a record review was conducted for the following residents: - Resident #64 was discharged on [DATE]. The MDS assessment Discharge Return Not Anticipated /End of PPS Part A Stay with an Assessment Reference Date (ARD) of 6/2/24 was completed on 6/5/24, however, the assessment was not transmitted to CMS' IQIES for over 120 days. - Resident #146 was discharged on [DATE]. The MDS assessment Discharge Return Not Anticipated with an ARD of 5/29/24 was completed on 6/6/24, however, the assessment was not transmitted to CMS' IQIES for over 120 days. - Resident #148 was discharged on [DATE], however, a discharge assessment was never completed as required. On 10/15/24 at 1:27 PM, during an interview with the MDS nurse #5, he/she stated that he/she transmitted weekly to CMS but with no specific days. She added that he/she transmitted the assessments within 7 days after completing an admission as well as discharge assessment. MDS nurse #5 stated that all assessments are required to be transmitted regardless of the payer source for Entry, Admission and Discharge assessments. MDS nurse #5 confirmed the concerns found by the surveyor and stated, these errors are all an oversight, we will fix them. (continued on next page)

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	215037	A. Building B. Wing	10/22/2024

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 2:00 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were made aware that 2 resident MDS assessments were not transmitted to CMS and 1 resident assessment was never completed and transmitted for over 120 days.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50502 Based on observation, record review, and interview, it was determined that the facility failed to accurately document oral assessment in a resident's medical record and code the resident's oral status accurately on the Minimum Data Set (MDS) assessment. This was evident for 1 (Resident #12) of 3 residents reviewed during the recertification/complaint survey. The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. 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 10/10/24 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 at 9:20 AM, an interview with Licensed Practical Nurse (LPN #8) revealed that nurses completed the oral assessments on admission and documented 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. 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. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 that he followed up on what items were missing. He further stated that if the resident had missing teeth, the nurses were expected to document the missing teeth in the progress notes. UM #9 stated that he developed and updated the care plans as needed. UM #9 was made aware that Resident #12's oral assessment was not accurately documented in the medical record. On 10/11/24 at 11:49 AM, in an interview with MDS nurse #5, she stated that before completing the items in an MDS assessment, he/she obtained information from the electronic health care record and physically assessed the resident. MDS nurse #5 showed the surveyor how he/she coded Section L-Oral/ Dental section in the MDS. He/she randomly selected Resident #12 and navigated to section L of a comprehensive MDS assessment with an Assessment Reference Date (ARD) of 3/5/24. She confirmed that she selected No as an option describing L0200. Dental- Option B No natural teeth or tooth fragment(s) (edentulous). He/she then clicked the tools in the MDS under the Resident Assessment Instrument (RAI) and confirmed that based on the guidance, he/she should have coded Yes no natural teeth to option B in section L- Oral/ Dental in the MDS assessment. On 10/17/24 at 2:10 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were made aware that Resident #12's admission oral assessment indicated has own teeth, the Baseline Care Plan indicated natural teeth' and the MDS assessment with an (ARD) of 3/5/24 was inaccurate because it did not capture Resident #12's missing teeth.

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	215037	A. Building B. Wing	10/22/2024

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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** 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)

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	215037	A. Building B. Wing	10/22/2024

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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)

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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)

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	215037	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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.

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	215037	A. Building B. Wing	10/22/2024

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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. 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:	(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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50502 Based on observation, interview and record review, it was determined that the facility failed to 1) follow professional standards of nursing practice when administering medications to residents and 2) administer the correct ordered medication form to the resident. It was evident for 1(Resident # 318) of 3 residents reviewed during medication administration during the recertification/complaint survey. The findings include: There are risks associated with opening capsules to drain the liquid. When this is performed, it alters the way the drug is absorbed in the body. This can result in people not getting enough dose. [Healtline.com February 2020] PAXIT is a 24-hour, unit-dose, medication management system in long-term care and it comes in easy to open bags. Omega 3 capsule is a dietary supplement made of gelatin and may have an enteric coating to prevent them from dissolving until they reach the small intestine. They are often tasteless and easy to swallow. Docusate Sodium is a medication utilized for managing and treating constipation. 1) On 10/16/24 at 8:51 AM, Licensed Practical Nurse (LPN #7), was observed preparing the medications of Resident #318. LPN #7 stated that Resident #318 took medications crushed. LPN #7 began popping the residents' medications from the blister packs, crushed and placed them in a small cup. He/she then proceeded to get an amber yellow semi-transparent gel capsule from a white PAXIT bag which contained one capsule of Omega 3 and placed it in a separate medication cup. He/she also took one red colored Docusate Sodium capsule from a small white bottle labeled house stock and placed it in the same medication cup where the Omega 3 capsule was placed. LPN #7 took a pair of green scissors that were sitting on top of the first drawer of the medication cart where the Over the Counter (OTC) medications and insulin pens were placed. He/she then wiped the scissors with an alcohol pad and told the surveyor not to worry about the scissors because they were not used for wound dressings, except for medications. LPN #7 cut the tips of the Omega 3 and the Docusate capsules and squeezed the liquid out from the capsules to the medication cup and mixed it with applesauce. The prepared medications were then administered to Resident #318. On 10/16/24 at 9:40 AM, in an interview with LPN #8 regarding the process of administering soft gel capsules to residents who had difficulty swallowing, he/she stated that the nurses, or the medication aids should not puncture the soft gel capsules before giving them to the residents, because it will affect the dose. He/she added that the nurses should call the doctor and have the medication changed to a liquid form. (continued on next page)

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	215037	A. Building B. Wing	10/22/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:11 AM, in an interview with the DON, she stated that if a resident took medications crushed but has orders for soft gel caps, the nurses are expected to call the doctor and ask for an order to change it to a liquid form. She added that she would come back and provide the surveyor with the policy. On 10/17/24 at 12:45 PM, the DON returned and handed the surveyor the facility's policy entitled, Medication Administration- Crushable Meds. It indicated that non-crushable medications should not be crushed, such as extended- release, enteric coated, soft capsules or medications designed to release over time. The DON also provided the surveyor an in- service education document entitled Medication Administration- Crushable Meds Education dated 10/16/24. 2) On 10/16/24 at 9:20 AM, a record review revealed an order that read, Docusate Sodium Oral Tablet 100 MG (Docusate Sodium) Give 1 tablet by mouth one time a day for Constipation. However, the medication that was given was in a soft gel capsule form. On 10/16/24 at 9:28 AM, LPN #7 confirmed that the medication that the was given to Resident #318 during medication pass was Docusate Sodium red soft gel cap and agreed that it should be tablet as ordered. On 10/17/24 at 1:50 PM, the DON and the Assistant Director of Nursing (ADON) were notified of the concerns observed during medication administration observation. The DON stated, we already educated the nurse concerned and the other nurses, so the error won't happen again. They were also notified that the nurse administered a soft gel capsule of Docusate Sodium instead of the tablet form.

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	215037	A. Building B. Wing	10/22/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 42507 Based on medical record reviews, resident and staff interviews, it was determined the facility staff failed to ensure that a resident was given pain medication consistent with professional standards of practice. This was evident for 1 (Resident #16) of 4 residents reviewed for pain management during the recertification/complaint survey. The findings include During an initial pool screen of Resident #16 on 10/7/2024 at 1:30 PM, the resident stated that s/he was always in pain and the pain medication was not given most of the time. Resident #16 further stated that sometimes s/he waited for a long time for the nurse to bring their pain medication. S/he added that the pain was in their stomach, knees, and legs. Review of Resident #16's clinical records on 10/9/2024 at 12:37 PM revealed the resident was readmitted to the facility in October 2024 with medical diagnoses that included but not limited to Chronic pain syndrome, unspecified Abdominal pain, and Prostate cancer. On 10/9/2024 at 1:02 PM, a review of active physician orders for Resident #16 revealed PRN (as needed) pain medication orders did not have parameters to correspond with pain scores for administration: - Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl): Give 1 tablet by mouth every 8 hours as needed for pain, start date 10/1/2024, - Acetaminophen Extra Strength Oral Tablet 500 MG (Acetaminophen): Give 2 tablets by mouth every 6 hours as needed for pain, start date 10/1/2024. On 10/9/2024 at 1:13 PM, record review revealed that Resident # 16's pain was not managed consistently: A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for October 2024 was completed. Staff documentation revealed that the resident was given: 10mg Oxycodone for a pain score of 6 on 10/4/2024 at 22:50 (10:50 PM), 10mg Oxycodone for pain score of 7 on 10/10/7/2024 at 13:41 (1:41 PM), 10mg Oxycodone for pain score of 0 on 10/7/2024 at 22:24 (10:24 PM), 10mg Oxycodone for pain score of 6 on 10/9/2024, and 10mg Oxycodone for pain score of 6 on 10/10/2024 at 00:04 (12:04 AM). Further review of Resident #16's MAR revealed that the resident received: 2 tablets of Acetaminophen 500mg for pain score of 3 on 10/5/2024 at 19:02 (7:02 PM), (continued on next page)

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	215037	A. Building B. Wing	10/22/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2 tablets Acetaminophen 500mg for pain score of 3 on 10/6/2024 at 21:51 (9:51 PM), and 2 tablets of acetaminophen 500mg for pain score of 0 on 10/7/2024 at 22:28 (10:28 PM). Resident #16 had no non-pharmacological (use of non-chemical methods to reduce pain without medications) interventions for pain management put in place. During an interview with Licensed Practical Nurse (LPN #12) on 10/16/2024 at 9:35 AM, he/she acknowledged that Resident #16 had chronic pain (mostly abdominal) but stated that the resident was on pain meds to manage their pain. He/she added that the expectation was to assess a resident's pain level and review the pain medication parameters prior to administering any PRN pain medication. On 10/10/2024 at 12:15 PM, an interview was conducted with the Director of Nursing (DON). DON reviewed and confirmed that the orders for PRN pain medications had no corresponding pain score parameters for administration and staff were not consistent with the administration of the meds. He/she stated that he/she was going to follow up with the doctor to address the PRN orders for Oxycodone and Acetaminophen. Regarding PRN administration of Oxycodone for a pain of 0 on 10/7/2024, DON stated that any prudent nurse will know that you don't give Oxycodone for a pain of 0. She added that anyone who knows the resident knows that his/her pain is never a zero. On 10/11/2024 at 9:22 AM, review of Resident #16's MAR for September 2024 revealed the resident was ordered Oxycodone HCL Oral tablet 10 MG, give 1 tablet by mouth every 8 hours for pain (6-10), may hold for sedation, start date 8/1/2024. However, staff documentation revealed the resident was given Oxycodone 10 mg for pain score of 5 on 9/8/2024 at 20:51 (8:51 PM). This was given outside ordered parameters of pain level (6-10). On 10/11/2024 at 10:18 AM, the Surveyor reviewed Resident #16's September MAR with the DON and the Assistant Director of Nursing (ADON). They both verified and confirmed that the Oxycodone 10 mg was given inappropriately on 9/8/2024 when the resident's pain score was below 6 (ordered parameters not followed). They acknowledged that Resident #16 should not have been given Oxycodone 10mg for a pain score of 5. However, both the DON and ADON stated that they were going to follow up with the staff regarding the administration of PRN pain meds.

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	215037	A. Building B. Wing	10/22/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50502 Based on observation, interview and record review, it was determined that the facility failed to administer the correct ordered medication form to the resident. It was evident for 1(Resident #318) of 3 residents reviewed during the medication administration during the recertification/complaint survey. The findings include: PAXIT is a 24-hour, unit-dose, medication management system in long-term care and it comes in easy to open bags. Omega 3 capsule is a dietary supplement made of gelatin and may have an enteric coating to prevent them from dissolving until they reach the small intestine. They are often tasteless and easy to swallow. Docusate Sodium is a medication utilized for managing and treating constipation. On 10/16/24 at 8:51 AM, Licensed Practical Nurse (LPN #7), was observed preparing the medications of Resident #318. LPN #7 stated that Resident #318 took medications crushed. LPN #7 began popping the residents' medications from the blister packs, crushed and placed them in a small cup. He/she then proceeded to get an amber yellow semi-transparent gel capsule from a white PAXIT bag which contained one capsule of Omega 3 and placed it in a separate medication cup. He/she also took one red colored Docusate Sodium capsule from a small white bottle labeled house stock and placed it in the same medication cup where the Omega 3 capsule was placed. LPN #7 took a pair of green scissors that were sitting on top of the first drawer of the medication cart where the Over the Counter (OTC) medications and insulin pens were placed. He/she then wiped the scissors with an alcohol pad and told the surveyor not to worry about the scissors because they were not used for wound dressings, except for medications. LPN #7 cut the tips of the Omega 3 and the Docusate capsules and squeezed the liquid out from the capsules to the medication cup and mixed it with applesauce. The prepared medications were then administered to Resident #318. On 10/16/24 at 9:20 AM, a record review revealed an order that read, Docusate Sodium Oral Tablet 100 MG (Docusate Sodium) Give 1 tablet by mouth one time a day for Constipation. However, the medication that was given was in a soft gel capsule form. On 10/16/24 at 9:28 AM, LPN #7 confirmed that the medication that the was given to Resident #318 during medication pass was Docusate Sodium red soft gel cap and agreed that it should be tablet as ordered. On 10/17/24 at 1:50 PM, the DON and the Assistant Director of Nursing (ADON) were notified that the nurse administered a soft gel capsule of Docusate Sodium instead of the tablet form.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 45131 Based on record review and staff interviews, it was determined that the facility failed to ensure that each resident was free from unnecessary antibiotic use. This was evident for 1 (Resident #19) of 3 residents reviewed for antibiotic use while performing infection control tasks during the recertification/complaint survey. Findings Include: According to the Center for Disease Control (CDC) COVID-19 (coronavirus disease 2019) is a disease caused by the SARS-CoV-2 virus. It can be very contagious and can spread quickly. The FDA has authorized or approved several antiviral medications to treat mild to moderate COVID-19 in people who are more likely to get very sick. Antiviral medications target specific parts of the virus to stop it from multiplying in the body once someone is infected, helping to prevent severe illness and death. On 10/15/24 at 08:35 AM, in an interview with Infection Preventionist RN (RN#26), the surveyor asked how the facility monitored antibiotic administration. RN #26 stated that the facility has an antibiotics stewardship program to monitor the unnecessary use of antibiotics throughout the facility. She noted that all antibiotics were kept on an Excel spreadsheet and reviewed daily. She stated that she had access to the Physician and pharmacist to clarify any concerns. She indicated that the team routinely discussed antibiotic usage during the monthly quality assurance meetings. The surveyor requested a copy of the antibiotic stewardship Excel spreadsheet. On 10/15/2024 at 12:55 PM, a review of Resident #19's Electronic Health Record (EHR) during the infection control survey task revealed the following: On 9/11/2024 at 2:13 PM, an attending Physician's (MD #37) progress notes stated, The patient states she has been having some difficulty with sinus pressure. Assessment Plan: weakness with mild URI. Check COVID/flu. Labs. On 9/11/2024 at 3:55 PM, a Registered nurse (RN #36) created an electronic medication order for a 5-day course of Azithromycin (antibiotic) daily to treat infection postnasal drip, COVID-19. On 9/11/2024 at 5:43 PM, Licensed Practical Nurse (LPN) #12's progress note revealed that Resident #19 COVID-19 test was positive. On 9/11/2024 at 10:48 PM, LPN #20's progress note revealed that Azithromycin loading dose was started. On 9/12/2024 at 15:26 (3:26 PM) attending physician MD #37 signed the Azithromycin electronic order created by RN #36. On 9/13/2024-9/16/2024, Resident #19's MAR for Azithromycin was signed, indicating that the medication was administered. (continued on next page)

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	215037	A. Building B. Wing	10/22/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 2:40 PM, a review of the facility's antibiotic stewardship spreadsheet revealed that Resident #19's Azithromycin section marked with a question mark. On 10/16/24 at 08:51 AM, in an interview with RN#26, the surveyor asked RN #26 to explain the reason for the question mark on the antibiotic stewardship Excel spreadsheet. RN #26 stated that the question mark identified a concern with Resident #26 antibiotic orders. RN #26 stated that antibiotics were not used to treat COVID-19. RN #26 said that it might be used for symptom treatment, but she was not sure why it was ordered. RN #26 stated, I will find out if I have any communication with the physician. On 10/16/24 at 02:10 PM, in a follow-up interview with the Infection Preventionist RN (RN#26), she stated that she was unable to provide documented evidence that the Physician was notified of the concern that Azithromycin was ordered for postnasal drip, covid. When asked about the necessity of Resident #19's Azithromycin order, RN #26 stated that she thought it was unnecessarily administered. On 10/17/24 at 1:46 PM, in an interview with MD #37, she stated, the resident may need Azithromycin for sinus issues. She had a history of congestion. Also CT was ordered by ENT. She stated that a COVID-19 test was ordered. During the interview, the surveyor shared the order (Azithromycin for postnasal drip, COVID-19), and she said, I didn't put in the order. I don't know why this one is put like this. It didn't make sense. I don't treat COVID with antibiotics. On 10/21/2024 at 11:45 AM, the surveyor informed the Director of Nursing (DON) of the above-mentioned findings and she acknowledged the issues discussed.

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	215037	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47200 Based on observations of the facility's kitchen, review of kitchen records, and interview of dietary staff it was determined the facility failed to: 1) ensure all dietary staff wore a hair restraint, 2) ensure stored foods were covered and labeled, and 3) ensure the dishwasher was maintaining the minimum wash temperature for sanitization of dishes. These deficient practices have the potential to affect all residents. The findings include: 1) On 10/7/24 at 7:51AM surveyors conducted an initial tour of the facility's kitchen. On 10/7/24 at 7:54AM surveyors observed Dietary Aide #30 at the serving line plating food with no hair restraint covering exposed hair. At this time the surveyor conducted an interview with Dietary Aide #30 who stated the following to the surveyor regarding not wearing a hair restraint for exposed hair: I'm sorry, it must have come off. At this time, Dietary Aide #30 was observed obtaining a hairnet. On 10/7/24 at 8:19AM the surveyor conducted an interview with Certified Dietary Manager (CDM) #31 who confirmed with the surveyor that their expectation was for staff to wear hair restraints. At this time, the surveyor shared their concern with CDM #31 who acknowledged and confirmed understanding of the surveyor's concern. On 10/11/24 at 1:45PM the surveyor shared all kitchen concerns with CDM #31 who acknowledged and confirmed understanding of the concerns. 2) On 10/7/24 at 7:58AM surveyors conducted a dual observation with CDM #31, and observed two uncovered cups of mandarin oranges and one cup of diced pears partially uncovered, exposed to air on a storage tray within the produce walk-in refrigerator. Upon further observation, approximately 5 out of 25 cups of fruit on the tray had no labeling/date/time etc. present on them. Upon further observation of other trays of food located within the produce walk in refrigerator, 3 out of 4 salads were observed with no labeling present on them. On 10/7/24 at 7:59AM the surveyor shared concerns and conducted an interview with CDM #31 who stated the following information regarding the fruit side items and salads observed: They should be dated, and they are not. At this time, CDM #31 acknowledged and confirmed understanding of the surveyor's concerns. On 10/11/24 at 1:45PM the surveyor shared all kitchen concerns with CDM #31 who acknowledged and confirmed understanding of the concerns. 3) On 10/11/24 at 1:43PM the surveyor observed the facility's dishwashing machine actively washing dishes after lunch service. The dishwasher's wash temperature at this time was observed to be 148F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/11/24 at 1:44PM the surveyor observed the placard present on the dishwasher which displayed the following manufacturer information regarding the minimum wash temperature for the machine: wash temperature minimum 160F. On 10/11/24 at 1:44PM the surveyor observed and reviewed the dishwasher temperature log which revealed the wash temperature did not meet the manufacturer's guidelines for use of the machine on 10/8/24 and 10/10/24. Temperatures recorded on the log by facility staff were 154F on both 10/8/24 and 10/10/24. On 10/11/24 at 1:45PM the surveyor conducted a dual observation of the dishwasher with CDM #31 who visually confirmed the wash temperature was 151F. At this time, the surveyor conducted an interview with CDM #31 who stated the following to the surveyor: We usually go by the 155F minimum temperature. When the surveyor inquired as to the manufacturer recommended wash temperature of 160F on the machine's placard, CDM #31 asked the surveyor: Where is the placard? At this time, the surveyor showed CDM #31 where the placard was located and they observed the minimum wash temperature of 160F on the placard and the surveyor shared their concerns. CDM #31 acknowledged and confirmed understanding of the concerns and reported to the surveyor that they would have maintenance staff look at the machine and confirmed that there was nothing they knew of that could be affecting the temperatures. At this time, the surveyor shared the temperature log concerns and all other kitchen concerns with CDM #31 who acknowledged and confirmed understanding of the concerns. CDM #31 was observed placing a phone call and stated the following to the surveyor: I'm calling maintenance now. Further review of the dishwasher temperature log revealed there was no documented corrective action or sign off of manager weekly review for 10/1-10/11/24 present on the log. On 10/11/24 at 1:58PM the surveyor observed the Director of Maintenance enter the kitchen and CDM #31 communicated to them that the wash temperature for the dishwasher was supposed to be 160F and was currently in the low 150's.

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	215037	A. Building B. Wing	10/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45131 Based on environmental observation, record review and staff interview, it was determined that the facility failed to have an effective system to prevent and control infections for all residents, staff, volunteers and visitors by posting precaution signs in front of residents' rooms to prevent the transmission of infections. This is evident for 3 (Resident #66, #68, #85) of 32 residents reviewed for infection precaution signs during the recertification/complaint survey. Findings include: According to the Center for Disease Control Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds, or indwelling medical devices such as central lines, urinary catheters, feeding tubes and tracheostomies). On 10/10/2024 at 09:03 AM, an environmental observation of Resident #68 room's revealed that there was no enhanced barrier precaution (EBP) sign in the room or on the door and the resident has tube feeding equipment at bedside. On 10/11/2024 at 11:50 AM, the surveyor requested a list of the facility's isolation precautions from DON and approximately 3 PM, the facility's isolation order list report was received. On 10/15/2024 at 08:35 AM, a record review of the order list report revealed that Resident #68 had an order for EBP; however, the sign was not posted to alert individuals entering the room of the additional precautions required. On 10/15/24 at 10:50 AM, during the infection control survey task, the surveyor conducted an environmental observation and the following issues were revealed: -An observation of 31 EBP facility identified rooms revealed that 2 (Resident # 68 and #85) of 31 EBP rooms did not have posted EBP signs in the room or on the door as required. -An observation also revealed that Resident #66 had a contact isolation precaution sign posted; however, the order was for EBP. On 10/15/2024 at 11:30 AM, record reviews revealed that EBP isolation orders were initiated on 5/30/2024 for Resident #68 and #85, and on 7/12/2024 for Resident #66. On 10/16/2024 at 08:51 AM, in an interview with the infection Preventionist (RN #26), she stated that the facility used the isolation signs to communicate with individuals entering and exiting the rooms about the necessary precautions that were required. She was notified of the above-mentioned findings and she stated that she will follow up. (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/2024 at 2:34 PM, in a follow-up interview with RN #26, she submitted a copy of the facility's internal communication email to address three Residents (#66, #68 and #85) isolation signs issues identified. On 10/21/2024 at 11:45 AM, the surveyor informed the Director of Nursing (DON) of the above-mentioned findings and she acknowledged the issues discussed.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45131 Based on record review and staff interview, it was determined that the facility failed to have documented evidence to support that the facility assessed the vaccination status of the influenza and Pneumococcal of each resident as required. This is evident for 3 (Resident #16, #127, and #152) of 5 randomly selected resident records reviewed for the influenza and pneumococcal vaccination records during the recertification/complaint survey. Findings Include: Influenza (Flu) vaccines are used to help prevent influenza. Influenza (Flu) is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people [AGE] years and older, pregnant people, and people with certain health conditions or a weakened immune system are at the greatest risk of flu complications (Centers for Disease Control and Prevention- vaccines and preventable disease). Pneumococcal vaccines are used to help prevent pneumococcal disease, which is any type of illness caused by streptococcus pneumonia bacteria. The Centers for Disease Control and Prevention (CDC) recommends a pneumococcal vaccine for ages [AGE] years or older and adults 19 through [AGE] years old with certain medical conditions or risk factors. (Centers for Disease Control and Prevention- vaccines and preventable disease). On 10/11/2024 at 12:51 PM, a review of the 5 randomly selected residents' vaccination records revealed the following deficient practices: - A review of Resident #127's records revealed the resident was admitted in September 2024. A review of the facility's immunization report tab under the electronic medical record form revealed that the facility failed to document Resident #127's flu vaccination status upon admission. Further review of Resident #127's scanned documentation session, the documentation named Maryland's immunization information system report (also known as Immunet report) showed the resident had last vaccinated for Flu in October 2019. However, the facility did not have any supportive documentation about Resident #127's Flu vaccination status upon his/her admission. - A review of Resident #152's records revealed that the resident was admitted in June 2024. A review of the facility's immunization report revealed that the facility failed to document the assessment of Resident #152's pneumococcal vaccine status upon admission. - A review of Resident #16's record revealed that the resident was admitted in July 2019. A review of the facility's immunization report revealed that the facility failed to document Resident #16's annual flu vaccine status for the year 2022. On 10/11/2024 at 2:10 PM, the surveyor requested and received a printout of the vaccination report for Resident #127, #152, and #16. A review of the residents' records revealed that Maryland's immunization information system reports had no additional information about Resident #152's pneumococcal vaccination status. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 08:35 AM, in an interview with the Infection Preventionist RN (RN#26), she stated that the facility's unit manager usually assessed residents' vaccination status and gave them opportunities to be vaccinated. Also, the unit manager routinely provided education for the vaccine at the time of the admission assessment. RN #26 confirmed that all the information regarding residents' immunization status should be documented under the electronic medical record. On 10/16/24 at 08:51 AM, The surveyor informed RN #26 of the above-mentioned findings in each resident record. The surveyor requested documented evidence to support that the facility completed the flu and pneumonia vaccination assessment; however, no additional documents were provided. On 10/21/2024 at 11:45 AM, the surveyor informed the Director of Nursing (DON) of the above-mentioned findings, and she acknowledged the findings.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 45131 Based on the record review and staff interview, it was determined that the facility failed to have documentation to support that the facility provided COVID-19 vaccine education regarding the benefits, risks, and potential side effects of the vaccines. This is evident for 1 (Resident #129) of 5 randomly selected residents reviewed for COVID-19 vaccination records during the recertification/complaint survey. Findings Include: On 10/11/24 at 12:51 PM, a review of Resident #129's vaccination records revealed that upon the resident's admission in March 2023, the resident refused the COVID-19 vaccine; however, a review of Resident #129's immunization report in the electronic medical record, documented the vaccination education for the COVID-19 as no. Thus, revealed that the vaccination education was not provided to the resident or their representative. On 10/15/24 at 08:35 AM, in an interview with Infection Preventionist Nurse (Staff#26), she stated that the facility's routine was to give the residents the opportunity to be vaccinated, and that education was routinely provided at the time of the admission assessment. The surveyor requested documented evidence to support the facility provided COVID-19 education, and Staff #26 stated that any education provided to the resident or resident's representative would be provided to the surveyor if available. On 10/16/24 at 08:51 AM, in an interview with Staff#26, he/she stated that the facility's unit manager reviewed Resident #129's charts for the COVID-19 vaccine and education status. However, the facility provided no additional evidence to support that the COVID-19 vaccine education was provided to Resident #129 or their representative. On 10/21/2024 at 11:45 AM, the surveyor reviewed the findings with the Director of Nursing (DON), and the findings were acknowledged.