| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215037 | A. Building<br>B. Wing | 03/03/2026 |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited:Based on observation, record review, and interview with facility staff, it was determined that the facility failed to maintain food service equipment in a manner that ensures sanitary food service operations to prevent possible foodborne illness. This was evident during the initial kitchen tour of the recertification survey. The findings include:A food-contact surface refers to any surface of equipment and utensils that typically comes into contact with food; or from which food may drain, drip, or splash onto food; or a surface that is usually in contact with food. Cross-contamination refers to the transference of harmful substances or pathogenic microorganisms to food by hands, food contact surfaces, sponges, cloth towels, kitchen equipment and/or utensils that have not been properly cleaned after contacting raw food and then touching ready-to-eat foods. Cross-contamination can also arise from inadequate dishwashing procedures that fail to effectively wash, rinse, sanitize, air-dry, and/or stored in sanitary conditions. On 02/24/2026 at 7:37 AM, surveyors conducted an initial tour of the kitchen with the General Manager (GM), and the following non-compliance were identified: The gaskets on the Victory #145 one-door reach-in unit were soiled.The green plastic guards located at the bottom of the tray cart within the Victory #144 one-door reach-in unit were observed to be torn, cracked, and pitted.The Victory #144 and #145 refrigerators were sealed to the [NAME] tiled floor, exhibiting uneven grouting along the bottom edges of the units. All surfaces in the kitchen must be smooth and easily cleanable to prevent the attraction of pests/insects and the proliferation of bacteria resulting from the accumulation of food particles, dirt, dust, and debris. 4. The dump sink faucet was not securely fastened to the sink basin. 5. Mold-like substances were present on the caulking where the unit was sealed to the wall. 6. The drain stopper was found to be broken. 7. The drain line was leaking directly onto the kitchen floor. 8. The floor sink and drain cover were unclean. 9. Fruit flies were observed around the drain line. 10. The water lines of the coffee and tea machines were missing backflow prevention devices. 11. The hand sink was not properly sealed to the wall. 12. The unit had two rusted components on the wall surface. 13. The bottom shelving units for clean dishes and clean utensils were less than 18 inches off the floor throughout the kitchen. 14. The clean equipment storage rack was placed on top of the grease trap interceptor. The grease trap interceptor may not be obstructed. 15. A door with a NOT an Exit sign posted adjacent to the eye-washing station was locked. All rooms and areas must be accessible to the surveyors. 16. The drain line of the 2-compartment food preparation sink was leaking graywater directly onto the kitchen floor. 17. The drain stoppers were found to be broken, rendering the vats unable to be filled. An interview with the kitchen GM revealed that staff utilized a smaller container to hold water when washing produce. 18. The wall-mounted knife holders were unclean. 19. The caulking on the wall sealing the 2-compartment sink was unclean and/or torn. 20. A countertop mixer was positioned next to the preparation sink without prevention of splashes. 21. Improper storage of ice buckets and the ice scoop was noted. 22. A wall-mounted bug zapper was positioned directly over an ice scoop. 23. The interior and exterior of the ice machine were unclean. 24. The ice machine bin door was pitted/cracked. 25. The replacement of the backflow prevention device could not be verified. 26. (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 |
|---|---|---|

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A clean dish rolling rack placed next to the employee two-door refrigerator and the dry storage room door was unclean. The clean dishes were positioned directly next to a 12 inch by 25 inch yellow wet floor sign. 27. Multiple floor tiles were damaged and cracked in the dry storage room. 28. The kitchen double doors leading to the additional storage room were kept open to access the storage room. Vestibule doors were found not to be tightly sealed with weather strips and door sweeps to prevent light gaps and avoid possible rodent/pest infestations. 29. The compressor fan covers for Walk-in #5 were unclean. 30. The compressor fan covers for Walk-in #4 were unclean. a. The refrigerator condensate line was not indirectly drained into the floor drain or floor sink. b. The drain pump and condensate line were covered in dust and debris. c. Condensate water was dripping directly over food products from the condensate line. d. The floors underneath the dunnage racks were unclean. e. The escutcheon plate was rusted. 31. The compressor fan covers for Walk-in #3 were unclean. a. The metal piece of the door frame on the bottom was lifted. b. The door gaskets on the bottom were torn. 32. New condensate line/sleeve covers were installed in Walk-in #2. a. However, condensate ice buildup was observed directly on top of food boxes. b. The door gaskets were warped. 33. The wall bug zapper was placed directly above the prep table at the ware washing station. 34. The wall-mounted fan was unclean at the ware washing station. 35. The Fiberglass Reinforced Plastic (FRP) panel walls exhibited chipping paint at the ware washing area. 36. A live cockroach was observed crawling on the wall at the ware washing area. 37. The cove base in the cart washing and chemical storage rooms were cracked, chipped, and/or lifted off the wall. 38. The trench drain in the cart washing room was unclean. 39. The cutting boards on the steam tables at the trayline were unclean. 40. The interior and exterior of Refrigerator #41 were unclean. 41. The door gaskets on the hot box/hot holding cabinet were torn. The door handle was loose. 42. The interior and exterior of the hot plate warmer unit were unclean exhibiting excessive dust, debris, and food spills. 43. The cookline preparation sink faucet was not securely fastened to the sink basin. 44. The drain line from the nonfunctional steam table was obstructing the flow of graywater into the floor sink, resulting in graywater splashing onto the kitchen floor. 45. The hot holding unit was nonfunctional. The unit was being utilized as a preparation table, and the steam wells were being utilized to store paper products. 46. The Chef Base Drawer Refrigerator was nonfunctional. A piece of cooking equipment was stored on top of the unit. 47. The double decker convection oven and the 3-vat deep fryer units were positioned outside the canopy hood overhang, resulting in improper airflow into the ventilation system. 48. All cooking equipment underneath the canopy hood were unclean. Excessive accumulation of dirt, dust, grease, and/or food spills was observed. 49. Grease droplets had formed on the canopy hood light covers, baffles, and fire suppression line. 50. Cleaning supplies (sponges) were placed next to the tilt skillet while food was being cooked in the unit. 51. The floor mixer was unclean. The unit exhibited rusted legs and chipping paint. 52. The in-counter preparation sink was nonfunctional. The faucet was dripping when the water line was shut off. 53. Fruit flies were observed by the hand sink area at the dish machine room. 54. The solids interceptor was leaking graywater directly onto the kitchen floor at the dish machine room. 55. Tube light bulbs were missing in the dish machine room. 56. The FRP panel walls exhibited chipping paint in the dish machine room. 57. The pre-rinse station drain line in the dish room was running across the middle of the floor and extended into the floor sink without an air gap to prevent siphonage. 58. Steam and vapors were escaping from both ends of the dish machine and spread throughout the kitchen area. 59. The chemical storage room door jamb and door frame were rusted and pitted on the bottom.At 11: 30 AM, an interview with the kitchen GM and the Maintenance Director was conducted to go over the list of the deficient practices listed above. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>Based on observations and facility staff interviews it was determined that the facility failed to have an accessible cord attached to the call light device in Resident bathrooms. This finding was found to be evident in 5 out of 34 Resident bathrooms observed on [NAME] Ground Nursing Unit which affected 5 (Resident #113, #115, #132, #161, and #172) out of 34 Residents reviewed for Resident Call System.The findings include:Resident Call Systems (nurse call systems) are essential communication tools in nursing homes that enable Residents to call for assistance via bedside stations, pull cords, or wireless pendants. These systems are critical for maintaining safety, independence, and fast emergency response for Residents.At 8:45 AM on 2/24/2026 upon touring the [NAME] Ground Nursing Unit the surveyor observed Resident bathrooms with a call light device on the wall next to the toilet. The call light device had no cord attached to the call light device on the wall for Resident #113, #115, #132, #161 and #172. In an interview with the Licensed Nursing Home Administrator (LNHA) and the [NAME] President of Facility Services/Maintenance (VP) at 11:30 AM on 2/27/2026 the surveyor conveyed that several call light devices in the Resident bathrooms on the [NAME] Ground Nursing Unit were observed without a pull cord attached to the call light device on the wall. The LNHA and [NAME] President observed the call light device in Resident #161's bathroom and there was not a pull cord attached to the call light device on the wall next to the toilet. The surveyor conveyed to the LNHA and [NAME] President the other Resident rooms that did not have a call light device pull cord in the Resident bathrooms. The VP stated that there were issues with the durability of the call light device pull cords.At 11:45 AM on 2/27/2026 the surveyor observed maintenance staff with call light device pull cords being installed on the call light devices in the Resident bathrooms on [NAME] Ground Nursing Unit. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on observation, and interviews with staff, it was determined that the facility failed to maintain a pest-free environment for the residents. This was evident in 6 of 6 areas reviewed during the recertification survey.The findings include:1) On 02/24/2026 at 7:50 AM, the surveyors noted the presence of fruit flies beneath the drainpipe of the coffee/tea preparation sink. 2) At 8:10 AM, the surveyors detected a live cockroach crawling on wall at the manual ware washing area.3) At 9:00 AM, the surveyors observed fruit flies in the vicinity of the dish machine hand sink, located in front of the chemical storage room.4) At 10:08 AM, a live cockroach was seen crawling on the floor of the laundry room by the surveyor. The Maintenance Director acknowledged the presence of the cockroach crawling near the laundry machine.5) At 10:30 AM, the surveyor returned to the kitchen janitor's closet with the Maintenance Director and the kitchen General Manager, where the light cover was found to have a significant number of dead insects. The Maintenance Director confirmed that the light cover would be cleaned.6) At 2:40 PM, the surveyor, accompanied by the Administrator, revisited the dish machine area. The surveyor indicated that a live roach was crawling on the leg of the dish machine. An interview with the kitchen General Manager revealed that a pest control contractor was scheduled to treat the premises weekly, every Wednesday. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff interviews and surveyor record reviews it was determined that the facility failed to document the offering and education of the formulation of an advance directive to Residents. This finding was found to be evident in 3 (Resident #144, #172 and #173) out of 9 Residents reviewed for advance directives.The findings include: Medical Orders for Life-Sustaining Treatment (MOLST) is a portable, actionable medical document for patients with serious, advanced illnesses to document preferences for CPR, intubation, and other life-sustaining treatments. Signed by a clinician, it is effective immediately across all care settings, including EMS and home.Advance Directives are legally binding documents, such as living wills and durable powers of attorney for healthcare, that specify your medical preferences if you become unable to communicate. Advance Directives take effect upon incapacity, requiring signatures from witnesses or a notary. Key types include living wills and medical powers of attorney.The surveyor conducted a record review on [DATE] at 12:15 PM of Resident #144's medical record. Review of the medical record revealed that there was a social services progress note on [DATE] at 15:03 PM that addressed review of MOLST with Resident and Responsible Party (RP). There was no documentation in the medical record that an advance directive was discussed with the Resident and/or RP.In an interview with the Social Services Coordinator (SW) at 12:30 PM on [DATE] the surveyor asked the SW what the expectation was for documentation of advance directives. The SW stated that there would be documentation in the Resident's medical record that advance directives were or were not on file and that if there was no advance directive on file, then Residents would be offered education to formulate an advance directive.In a follow up review of Resident #144's medical record on [DATE] it revealed that the SW documented a progress note at 13:33 PM on [DATE] that the MOLST was reviewed with the Resident and that there were no advance directives on file, and that Resident was offered to complete Advance Directives and declined.The surveyor conducted a record review on [DATE] at 12:15 PM of Resident #172's medical record. Review of the medical record revealed that there was a social services progress note on [DATE] at 14:01 PM that addressed review of MOLST with Resident and no advance directives on file. In an interview with the Social Services Coordinator (SW) at 12:30 PM on [DATE] the surveyor conveyed that Resident #172 did not have an advance directive on file and that there was no documentation that Resident was offered education to complete an advance directive. The SW reviewed the progress notes for Resident #172 and acknowledged the surveyor and stated that he/she missed documenting advance directives for this Resident and that he/she would address advance directives with this Resident.In a follow up review of Resident #172's medical record on [DATE] it revealed that the SW documented a progress note at 13:20 PM on [DATE] that the Resident was offered to complete an advance directive and declined.The surveyor conducted a record review on [DATE] at 12:15 PM of Resident #173's medical record. Review of the medical record revealed that there was no documentation that Resident did or did not have an advance directive and/or offered education on formulation of an advance directive.In an interview with the Social Services Coordinator (SW) at 12:30 PM on [DATE] the surveyor conveyed that Resident #173 did not have an advance directive on file and that there was no documentation that Resident was offered education to complete an advance directive. The SW reviewed the progress notes for Resident #173 and acknowledged the surveyor and stated that he/she missed documenting advance directives for this Resident and that he/she would address advance directives with this Resident.In a follow up review of Resident #173's medical record on [DATE] it revealed that the SW documented a progress note at 13:20 PM on [DATE] in the medical record that Resident did not have an advance directive on file and that Resident was offered to complete an advance directive and declined. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observation and interview with facility staff, it was determined that the facility failed to ensure that the environment of the resident was kept clean, comfortable and sanitary. This was evident for Resident #14 during the annual re-certifications survey. The findings include: On 02/25/2026 at 9:45 AM, during the initial observation of Resident #14's room revealed two items on the floor: a grey bed pan in the bathroom, located under the sink, and a blue surgical mask, which appeared to have been worn, in the corner of the room. On 02/25/2026 at 10:00 AM Staff #16, Unit Manager, Registered Nurse (RN) was shown the bed pan and the blue mask which appeared used on the floor. Staff #16, RN verbalized understanding that the above items being on the floor was an issue and called housekeeping to remove the items. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on staff and Resident interviews and surveyor record reviews it was determined that the facility failed to notify Residents/Resident Representatives in writing of the bed hold policy and document notification of the bed hold policy when Residents were transferred to the hospital. This finding was found to be evident in 2 (Resident #172 and #9) out of 5 Residents reviewed for discharge process. The findings include:<br><br>Hemodialysis is a life-sustaining treatment for kidney failure that removes waste and excess fluid, typically taking 3-4 hours per session, 3 times a week. Dialysis is required when kidneys can no longer adequately filter waste and excess fluid from the blood. Blood is removed, filtered through an artificial kidney machine, and returned to the body.<br><br>Arteriovenous fistula (AV fistula) is an abnormal, often surgically created, connection between an artery and a vein, allowing blood to bypass capillaries. Commonly used for hemodialysis in the arm.<br><br>In an interview with Resident #172 on 2/24/2026 at 1:09 PM he/she stated that he/she received dialysis here at the facility and recently went to the hospital for bleeding from the dialysis fistula after one of the dialysis sessions.<br><br>The surveyor conducted a record review of Resident #172's medical record on 2/26/2026 at 9:10 AM. Review of the medical record revealed that Resident #172 was transferred to University of Maryland – Midtown hospital on 2/5/2029 due to bleeding from the AV fistula site post dialysis session.<br><br>Further review of the medical record for Resident #172 revealed that there was no documentation of notification to the Resident/Responsible Party of the bed hold policy when Resident #172 transferred to the hospital on 2/5/2026.<br><br>In an interview with the Assistant Director of Nursing (ADON) on 2/26/2026 at 12:05 PM the surveyor asked what was the expectation for documentation of notification of the bed hold policy to Residents or Resident's Responsible Party when Residents transferred to the hospital. The ADON stated that the expectation was for the nursing staff to document in the progress notes of the medical record the bed hold notification to the Resident or Resident Representative. The ADON stated that there was no progress note indicating that the bed hold policy was given to Resident or the Resident's Responsible Party for the 2/5/2026 transfer to the hospital for Resident #172.<br><br>On 03/02/2026 at 8:15 AM: A review of Resident #9's medical records indicated that on 2/18/2026, Resident #9 was sent to the hospital after experiencing low blood pressure during a<br><br>vascular appointment.<br><br>On 03/02/2026 at 9:36 AM: Administrative Assistant Staff #15 was interviewed and asked to provide documentation confirming that Resident #9's responsible party (RP) was notified of the bed hold policy. Staff #15 stated they would check and follow up.<br><br>On 03/02/2026 at 11:34 AM: Staff #15 was interviewed again and reported they could not provide written documentation that Resident #9's RP was given the bed hold policy upon the resident's transfer to the hospital. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on clinical record review and interview, it was determined that the facility failed to transmit a Minimum Data Set (MDS) assessment within 14 days of completion of the assessment. This was evident for 1 (Resident #133) of 3 residents reviewed for assessments transmission during the annual 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 and Medicaid. MDS assessments need to be accurate to ensure each resident receives the care they need.On 03/03/2026 at 10:00 AM a review of Resident #133's clinical record revealed that the resident was discharged on 11/11/2025. The MDS Assessment Discharge Return (ADR), Not Anticipated with ADR of 11/11/2025, was completed on 11/17/2025. However, the assessment was not transmitted to CMS.On 03/03/2026 at 12:00 PM during a telephone interview, MDS Consultant #22 reviewed Resident #133's MDS assessment and confirmed that the assessment was completed but not submitted to CMS. Staff #22 stated, I am going to submit it nowThe Administrator was notified of the findings on 03/03/2026 at 12:15 PM. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff interviews and surveyor record reviews, it was determined that the facility failed to accurately complete Minimum Data Set assessments (MDS) on Residents. This finding was found to be evident in 2 (Resident #26 and #171) out of 9 Residents reviewed for accurate coding of MDS assessments. The findings include:Minimum Data Set (MDS) assessment is a federally mandated, standardized, comprehensive clinical assessment tool used in Medicare / Medicaid certified nursing homes to evaluate Residents' functional, medical and psychological status. Completed by interdisciplinary teams on admission, quarterly, annually, upon significant change and discharge. The MDS dictates care planning and reimbursement and is completed by trained clinical staff.Care Plan is a documented, living guide outlining a person's health, treatment goals, and necessary services, tailored to their physical, mental, and social needs. Created collaboratively by patients and providers, it includes medication lists, clear and actionable goals. It promotes consistent care and improves quality of life. The surveyor conducted a record review of Resident #26's medical record on 2/26/2026 at 11:15 AM. Review of Resident #26's medical record revealed that the Resident had an active physician order for an anticoagulant medication (blood thinner), Xarelto for atrial fibrillation (fast, irregular heart rhythm) as of 2/4/2026. Additionally, Resident #26 had a current care plan problem for anticoagulant therapy (Xarelto) for atrial fibrillation as of 2/5/2026.Further review of Resident #26's medical record revealed that the admission and Medicare 5-Day Minimum Data Set (MDS) assessments Section N - Medications dated 2/11/2026 was not coded that Resident was taking an anticoagulant medication.In an interview on 2/26/2026 at 12:05 PM the surveyor reviewed with the facility's MDS Consultant the MDS assessments dated 2/11/2026, the care plan and the physician orders for Resident #26. The surveyor conveyed to the MDS Consultant that Resident #26 had an active physician order, and a current care plan for Xarelto, and that an anticoagulant was not coded on the MDS assessments dated 2/11/2026. The MDS Consultant reviewed the MDS assessments, acknowledged the surveyor, and stated that he would notify the Licensed Nursing Home Administrator (LNHA) of the error in coding of the MDS assessments. In a follow up record review on 2/27/2026 at 1:00 PM of Resident #26's MDS assessments the review revealed that on 2/26/2026 at 1:43 PM and 1:44 PM a correction in coding was made to both MDS assessments dated 2/11/2026 which reflected that Resident #26 was taking an anticoagulant medication. The facility management provided the surveyor with copies of Section N of the MDS assessments dated 2/11/2026 indicating the modification and correction in the coding of anticoagulant medication for Resident #26.On 3/2/2026 at 8:50 AM the surveyor conducted a record review of Resident #171's closed medical record. Record review of the progress notes revealed that Resident #171 was discharged to the hospital on 1/22/2026. Further review of the medical record revealed that the Discharge - return not anticipated MDS assessment dated [DATE] revealed that Resident #171 was discharged home under care of organized home health service organization. In an interview with the Licensed Nursing Home Administrator (LNHA) at 9:25 AM on 3/2/2026 the surveyor conveyed to the LNHA that the Discharge MDS assessment dated [DATE] was coded that Resident #171 was discharged to home under home health services. However, according to documentation in the progress notes Resident #171 was discharged to the hospital. LNHA stated that Resident #171 was discharged to the hospital on 1/22/2026.In a follow up interview with the LNHA at 2:45 PM on 3/2/2026 s/he provided a copy of the correction to the modification of the MDS assessment completed at 12:47 PM on 3/2/2026 which was coded that Resident #171 was discharged to short term general hospital (acute hospital) on 1/22/2026. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and interviews, it was determined the facility failed to ensure that interdisciplinary care plans were reviewed and revised following a change in condition related to Resident falls and Resident treatments. This was found to be evident for 2 (Resident #143 and #92) out of 4 Residents reviewed for care planning during the annual recertification survey. The findings include:<br><br>On 02/24/2026 at 8:02 AM, during an interview, Resident #143 reported a recent fall during an interview. Resident #143 stated that while self-transporting to the bathroom via wheelchair, he/she fell and could not reach the call cord due to the distance. Resident #143 reported lying there for a period of time, calling out for help. The resident expressed that he/she is now experiencing increased discomfort and difficulty moving the left foot, which he/she feels is requiring more assistance with transport to the bathroom.<br><br>On 03/02/2026 at 11:02 AM, a review of Resident #143's medical record revealed two documented falls. A progress note dated 02/20/2026 titled SBAR at 05:14 AM stated the resident was heard yelling for help and was found on the bathroom floor during rounds. A separate progress note dated 02/02/2026 at 12:11 PM revealed the resident was observed on the floor between the wheelchair and the toilet, with their legs toward the door.<br><br>On 03/02/2026 at 11:27 AM, further review of Resident #143's medical record revealed a care plan, initiated 04/14/2023, addressing actual fall without any injury and poor balance. Interventions, dated 11/06/2024 and revised 01/17/2025, included the following: bed in low position, call bell/personal items within reach (in bed/out of bed (OOB) to chair), [NAME] to wheelchair seat (OOB to chair), encouraging use of a reacher, and ensuring appropriate footwear (nonskid socks/rubber sole shoes) when OOB to chair. (Date initiated/revision: 01/17/2025 for all except the reacher revision: 10/17/2025). However, there was no evidence that the fall care plan had been revised with further interventions to prevent falls despite the two falls that occurred on 02/20/2026 and 02/02/2026.<br><br>On 03/02/2026 at 1:50 PM, the Assistant Director of Nursing (ADON) described the fall process: the nurse assesses the resident, completes documentation, investigates, notifies the physician/responsible party, and would revise the person-centered care plan (or would update the date in the fall care plan if an existing intervention applies). The ADON confirmed that Resident #143's fall care plan had not been revised to prevent further falls following the two falls in February and was made aware of the concern at this time.<br><br>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<br><br>A review of Resident # 92's clinical record on 02/27/26 at 10:46 AM revealed that the resident received antibiotic therapy, Amoxicillin-Pot Clavulanate every 12 hours for Bronchitis from 01/08/2026 – 01/12/2026 and a care plan was initiated on 01/09/2026.<br><br>A further review of the clinical record revealed that Resident #92's care plan remained active and it stated (Resident Name) is on PO antibiotic therapy r/t Bronchitis and elevated WBC of 11.8. The care plan failed to reveal the resident's antibiotic therapy ended on 01/12/26.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 02/27/26 at 11:15 AM during an interview the Director of Nursing (DON) reviewed Resident #92's clinical records and confirmed the surveyor's findings. The DON stated that she would look into the matter. After the surveyor's intervention, the care plan was resolved on 02/27/2026 and the DON provided the surveyor with a copy of the documentation. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interview and record review, it was determined that the facility failed to 1) ensure an ordered procedure necessitated an outside scheduled appointment was completed, and 2) properly assess, evaluate, and implement physician recommendations for treatment of skin impairments. This was evident for 3 (Resident #109, #22, and #166) of 11 residents reviewed during the annual survey. The findings include: According to the University of Maryland Medical System, a Modified Barium Swallow (MBS) is a fluoroscopic procedure designed to determine whether food or liquid is entering a person's lungs, also known as aspiration. It permits the medical team to observe the coordination of anatomical structures in the mouth and throat as they are actively functioning when chewing, drinking, and swallowing. 1) On 02/24/2026 at 11:54 AM, during an interview with Resident #109, he/she voiced concern that food sometimes gets stuck in his/her throat.On 02/25/2026 at 2:01 PM, a review of Resident #109's physician orders revealed an order dated 12/05/2025 to obtain a modified barium swallow study to evaluate swallowing. However, further review of Resident #109's medical record lacked evidence the modified barium swallow test was scheduled. On 02/25/2026 at 2:16 PM, the Director of Nursing (DON) described the process for outside appointments (e.g., modified barium swallow study). Orders are reviewed daily in the clinical meeting. There is a form on each unit in a binder with appointment information. The form has the destination, information regarding the appointment, and accompanying person details. Once scheduled, the appointment information is updated in the physician orders with appointment details of date, time, and location for the nurse's awareness of the appointment. The concern was shared with the DON at this time. 2) On 02/24/2026 at 11:30 AM, observation of Resident #22 lying in bed, with the entire left great toe exhibiting redness. On 02/27/2026 at 10:55 AM, a review of Resident #22's medical record revealed a wound physician's 12/2/2025 note at 3:47 PM documented a left foot first toenail bed infection/paronychia (a skin infection) with purulent drainage and erythema, recommending a podiatry consult for further evaluation and management. A subsequent 01/06/2026 wound physician note at 6:46 PM showed the left foot paronychia measuring 3.0 cm x 3.0 cm. However, there was no further assessment of the left great toe for 21 days, until a podiatry consult dated 01/27/2026. On 2/27/2026 at 11:03 AM, continued review of podiatry consults provided to the surveyor by the Assistant Director of Nursing for Resident #22 included the following: A 12/31/2026 consult recommended applying ketoconazole daily, leaving the feet open to air, and placing gauze between the first and second toe. A second consult dated 01/27/2026 advised applying antifungal cream daily without a dressing. However, the treatment administration record for December and January showed an existing order (start date 11/13/2025) to cleanse the left great toe with normal saline, apply bacitracin, and cover with a foam dressing daily, indicating two treatment plans were not implemented. On 02/27/2026 at 11:40 AM, the Assistant Director of Nursing (ADON) explained that the nurse who accompanies the physician during rounds is responsible for managing consult recommendations and treatment plans. It is expected that all recommended treatment plans for skin impairments are implemented. Furthermore, skin impairments must be monitored weekly for changes (either healing or worsening). Weekly wound rounds are conducted, which require a documented description of the wounds. This concern was communicated to the ADON at that time. On 03/02/2026, Resident #166's medical record review noted a baseline care plan (11/5/2025) aiming for skin integrity/improvement, indicating skin not intact due to a surgical site and pressure injury. The pressure injury was not described further. A subsequent skin assessment (11/06/2025) only indicated a sacral wound, also lacking description. On 03/02/2026 at approximately 9:40 AM, a review of Resident #166's medical record revealed a wound physician note from 11/18/2025 at 11:40 PM. The note indicated a sacral MASD (moisture-associated skin damage) measuring 7.0 cm x 2.5 cm x 0.2 cm, with 80% intact skin and 10% necrotic tissue. The plan was to apply zinc paste every shift and as needed. However, further review of Resident #166's treatment administration record for the month of November 2025 showed the sacral wound continued<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to be treated daily with Greer's Go (started 11/06/2025), indicating the zinc paste treatment ordered on 11/18/2025 was not implemented. On 03/02/2026 at 12:05 PM, the Assistant Director of Nursing (ADON) was interviewed regarding the wound process. The ADON stated a nurse completes a head-to-toe skin assessment on admission, documenting any identified wounds with a detailed description and monitoring them weekly. Wound physician-recommended treatment plans should be implemented when received and followed. Concerns were shared with the ADON. On 03/03/2026 at approximately 1:50 PM, the concerns were shared with the Director of Nursing. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on medical record review and staff interviews, it was determined the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice. As evidenced by not evaluating the effectiveness of treatment orders or timely and accurately assessing wounds. This was evident for 1 (Resident #109) of 4 residents reviewed for pressure ulcers during the annual survey. The findings include: According to the Centers for Disease Control (CDC), pressure ulcers (bed sores, pressure sores, or decubitus ulcers) are wounds from unrelieved pressure on the skin. They are staged by severity: Stage 1 is persistent skin redness; Stage 2 is partial thickness loss (abrasion, blister, or shallow crater); Stage 3 is full thickness loss exposing subcutaneous tissue (deep crater); and Stage 4 is full thickness loss exposing muscle or bone. An unstageable ulcer involves full-thickness skin and tissue loss where the extent of damage is obscured by slough or eschar.The standard of practice for the care of pressure ulcers is for the facility staff to conduct weekly assessments and document findings that include the location, measurement, stage, and characteristics of a pressure ulcer. This information provides facility staff with information to determine whether the pressure ulcer is healing or worsening at future assessments and to evaluate which treatment plan would be most effective to heal the pressure ulcer. On 02/26/2026 at 8:55 AM, review of Resident #109's care plan, initiated 01/17/2023 (revised 09/30/2025), revealed a focus on a Stage IV sacral pressure ulcer due to immobility and comorbidities. Interventions, initiated 01/17/2023 (revised 11/15/2024), included: Administer ordered treatments and monitor effectiveness; and monitor/document/report as needed changes in skin status (appearance, color, healing, signs and symptoms of infection, wound size, and stage). On 02/26/2026 at 8:10 AM, a review of Resident #109's medical record indicated a 10/16/2024 physician order for daily sacrum wound treatment: cleanse with Hypochlorous Acid Solution 0.012%, apply moist-to-dry gauze soaked in the solution, and cover with bordered gauze every day shift, as needed. On 02/26/2026 at 8:47 AM, a review of Resident #109's progress notes revealed a wound physician note from 2/3/2026 at 5:00 PM documenting a Sacrum stage IV pressure injury: 5.9 CM X 1.6 CM X 0.8 CM, with no necrotic tissue. On 02/26/2026, at approximately 8:50 AM, further review of Resident #109's medical record revealed a 02/10/2026 wound observation tool. This tool indicated that the sacral stage 4 wound was worsening, described the tissue as moist, and measured 6 cm X 2 cm X 1.2 cm. However, the documentation failed to demonstrate the effectiveness of the current hypochlorous treatment, initiated on 10/16/2024. Furthermore, the documentation did not include the characteristics of the wound's appearance.On 02/26/2026 at approximately 9:00 AM, continued review indicated a wound physician's note dated 2/24/2026 at 4:46 PM of the sacrum stage IV injury measured 4.3 cm x 2.0 cm x 1.6 cm, with no necrotic tissue; however, further review revealed there was no documented assessment of Resident #109's sacral wound from 02/10/2026 until the 02/24/2026 assessment-a period of 14 days without monitoring. On 02/26/2026 at 9:12 AM, during an interview, the Assistant Director of Nursing (ADON) described the facility's wound care process. Wound rounds are conducted weekly, and a documented description of the wounds is required. The ADON indicated that a change in treatment order is expected if a wound is not improving or is deteriorating, which should include notifying the physician, as this course of action is driven by the nurse's assessment. At this time the concern was shared with the ADON. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observations, interviews and surveyor record reviews it was determined that the facility failed to provide safe, appropriate respiratory care and services. This finding was found to be evident at the nursing station on [NAME] Ground Nursing Unit and in 2 (Resident #113 and #173) out of 2 Residents reviewed for usage of oxygen and storage of oxygen.The findings include: On 2/24/2026 at 9:57 AM the surveyor observed an emergency tank of oxygen (etank) at the nursing station on [NAME] Ground Nursing Unit. The etank was in an upright position and not secured in a stand or bracket.In an interview with Registered Nurse (RN) #14 at 10:05 AM on 2/24/2026 the surveyor asked what the expectation was for storage of oxygen and showed RN #14 the etank that was standing upright, not secured, not in a stand at the nursing station. RN #14 stated who put that there and removed the etank to the oxygen storage room.On 2/24/2026 at 11:20 AM the surveyor observed Resident #113 in no distress sitting in the chair in Resident room with oxygen cannula (tubing) in his/her nostrils. Observed in the Resident bathroom was a wheelchair with an emergency tank of oxygen (etank) secured in the back pocket of the wheelchair. There was no oxygen signage on the Resident room door to indicate that an oxygen emergency tank (etank) was in the Resident room.The surveyor conducted a record review of Resident #113's medical record on 2/26/2026 at 3:00 PM. Record review revealed that Resident #113 had active physician orders for oxygen therapy and services.On 2/24/2026 at 1:40 PM the surveyor observed Resident #173 in his/her room ambulating with oxygen cannula (tubing) in his/her nostrils. Observed in the Resident room was an emergency tank of oxygen (etank) secured in an oxygen stand. There was no oxygen signage on the Resident room door to indicate that an emergency tank of oxygen (etank) was in the Resident room.The surveyor conducted a record review of Resident #173's medical record on 2/26/2026 at 3:25 PM. Record review revealed that Resident #173 had active physician orders for oxygen therapy and services.The surveyor on 2/26/2026 at 3:45 PM reviewed the facility's Oxygen Tank Storage Policy dated 5/2023 which indicated that when the oxygen tank was in the Resident room the oxygen tank should be placed in its holder stand at all times.The facility management team was notified of the concern with oxygen usage and storage during the survey exit. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on medical record review and interviews with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists in a timely manner. This was true for (Resident #13) reviewed during the annual re-certification survey.The findings include:On 02/27/2026 at 1:15 PM: The Director of Nursing (DON) was interviewed about the Medication Regime Review (MRR) process. The DON stated that monthly MRRs are emailed by the pharmacist, printed, and followed up on by the nursing team or physician. New orders are then updated, placed in Point Click Care (PCC), and the recommendation is uploaded to PCC. Once the physician updates the recommendations, the changes are sent back to the pharmacist via medical records.03/02/2026 at 1:00 PM: Resident #13's MRR, dated 6/28/2025, was reviewed. The review indicated that the recommendations to increase Allopurinol and decrease Tiotropium were not addressed in a timely manner. Staff #15, a Registered Nurse and Unit Manager, signed the 6/28/2025 MRR on 8/28/2025 and documented the order update on the same date.On 03/03/2026 at 9:30 AM: The Licensed Nursing Home Administrator (LNHA) was interviewed regarding Resident #13's MRR dated 6/28/2025 not being addressed until 8/28/2025. The LNHA was asked to provide additional documentation to show the MRR was addressed before 8/28/2025. The LNHA confirmed that no other documentation was available and verbalized an understanding that this was a issue. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on facility staff interviews and surveyor record reviews it was determined that the facility failed to follow a physician medication order for a Resident, failed to provide adequate side effects monitoring for Residents on psychotropic medications, and failed to ensure a Resident's medication regimen was free from unnecessary psychotropic medication as evidenced by medical records lacking physician documentation of rationale for continued as needed psychotropic use, no documented monitoring of side effects, and no documented non-pharmacological interventions prior to medication administration. This finding was found to be evident in 4 (Resident #26, #33, #92 and #7 ) out of 5 Residents reviewed for unnecessary medications during the annual recertification survey. The findings include:<br><br>Medication Administration Record (MAR) is a legal and essential document used by healthcare professionals to track, verify, and record all administered, missed or refused doses of medication, ensuring patient safety and regulatory compliance. The MAR includes patient information, medication details, doses, routes, and times.<br><br>On 2/26/2026 at 11:15 AM the surveyor conducted a record review of Resident #26's medical record. Review of the medical record revealed that Resident #26 had a physician order for Metoprolol extended release 100 mg daily for hypertension. Additionally, there were parameters to hold the medication if the systolic blood pressure was less than 100.<br><br>Further review of Resident #26's medical record, specifically the medication administration record revealed that Resident was administered Metoprolol on 2/8/2026, 2/10/2026 and 2/12/2026 at 9:00 AM, however, the systolic blood pressure was documented as 98, 98 and 97, respectively which were less than 100.<br><br>At 2:15 PM on 2/26/2026 in an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) the surveyor reviewed that Resident #26 had a physician order for Metoprolol extended release 100 mg daily for hypertension hold for systolic blood pressure less than 100. Additionally, the surveyor conveyed that the Metoprolol was administered by the nurses to the Resident on 3 days (2/8, 2/10 and 2/12) when the systolic blood pressure was less than 100. The ADON and DON reviewed Resident #26's medication administration record, acknowledged the dates that the Metoprolol was administered when the systolic blood pressure was less than 100, and stated that they would address with the nurses.<br><br>No additional information was provided by the facility at the time of exit.<br><br>Psychotropic medications are drugs that affect the brain and central nervous system, altering mood, thoughts, perceptions, and behaviors. They are primarily used to treat mental health conditions, such as anxiety, depression, schizophrenia, and bipolar disorder.<br><br>On 02/26/2026 at 1:00 PM a review of Resident #33's clinical record revealed that the resident was receiving psychotropic medications from 02/11/2025 as follows:<br><br>Seroquel 25 mg two times a day for Dementia with Behavioral Disturbance<br><br>Seroquel 37.5 mg at Bedtime for Dementia with Behavioral Disturbance<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Trazodone HCL 25 mg in the evening for Depression<br><br>On 02/27/2026 at 8:53 AM a review of Resident #92's clinical record revealed that the resident was receiving psychotropic medications from 01/20/2026 as follows:<br><br>Mirtazapine 15mg at Bedtime for Depression<br><br>Sertraline HCL 25mg every day for Anxiety/Depression<br><br>Further review of Resident #33 and Resident #92's clinical records failed to reveal a process for adequately monitoring the residents for side effects of psychotropic drugs to include the frequency and tools used for monitoring.<br><br>On 02/27/2026 at 11:15 AM during an interview with the Director of Nursing (DON) and Unit Manager #29, the DON stated that it was the facility's practice to monitor residents on psychotropic drugs for side effects. The DON reviewed the records and confirmed the surveyor's findings.<br><br>On 03/02/2026 at 9:20 AM Unit Manager #29 stated that after the surveyor interviewed herself and the DON, she updated Resident #33 and Resident #92's Medication Administration Record on 03/01/2026 to include monitoring for side effects and conducted an Inservice training for the licensed nurses on documentation.<br><br>According to the National Institutes of Health (NIH), psychotropic medications (also known as psychoactive or psychopharmacological medications) are defined as drugs or substances that affect the central nervous system to alter brain chemistry, which in turn modifies an individual's thoughts, emotions, behaviors, perceptions, or awareness. The NIH (via the National Library of Medicine) typically classifies these into five major categories: antidepressants, anti-anxiety, antipsychotics, mood stabilizers, and stimulants.<br><br>On 03/02/26 at approximately 1:30 PM, review of Resident #7's physician order with a start date of 12/18/2025 at 6:30 PM for hydroXYZine HCl Oral Tablet 25 MG (anti-anxiety medication), to be given as 1 tablet by mouth every 6 hours as needed for anxiety, for a duration of 90 days. However, a subsequent review of Resident #7's medical record revealed a lack of physician documentation providing a rationale to continue this medication.<br><br>On 03/02/26 at approximately 1:35 PM, a review of Resident #7's January and February 2026 medication administration record showed hydroxyzine was given once in January and three times in February. However, the medical record lacked documentation of side effect monitoring and non-pharmacological interventions prior to its administration.<br><br>On 03/02/2026 at 3:16 PM, the Director of Nursing (DON) stated that psychotropic medication side effect monitoring and non-pharmacological interventions for as needed psychotropics are currently documented in progress notes. To improve documentation, the monitoring processes for side effect monitoring will be added to medical record batch orders. All psychotropic orders that are as-needed should be limited to 14 days, with physician rationale required for continuation. The concern was shared with the DON at this time. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215037 | A. Building<br>B. Wing | 03/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Keswick Multi-Care Center | 700 West 40th Street<br>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.

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|---|---|
| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide routine and 24-hour emergency dental care for each resident.<br><br>Based on interviews and clinical record review, it was determined that the facility failed to assist a resident to obtain routine dental care. This was evident for 1 (Resident #2) of 2 residents reviewed for dental services.The findings include:During an interview on 02/25/2026 at 7:26 AM Resident #2 stated that his/her teeth needed cleaning and that he/she had been waiting for 6 months for the facility to make an appointment. On 02/27/2026 at 8:00 AM a review of Resident #2's clinical record revealed the following:A progress note by the physician dated 10/01/2025 stated . The patient also request to follow-up with a dentist at the dental school. Patient requests appointment.A Physician's Order dated 10/01/2025 stated Refer to (Name) dental school for dental cleaning per resident request.A progress note by the physician dated 01/14/2026 stated . The patient also is pending follow-up with a dentist. The patient is not aware of an appointment yet.A progress note by the psychotherapist dated 02/06/2026 stated . client is just wanting to get into his dental appointment. client said I've only been waiting for 6 months now client vented about frustrations and wanting to get garbage out of his mouthFurther review of the clinical record revealed the facility failed to follow up on the physician's order for dental services for Resident #2.On 02/27/2026 at 12:30 PM the Director of Nursing (DON) in an interview stated that the resident was offered dental services on 06/26/2025 but refused. The DON did not explain why the physician's order which written on 10/01/2025, three months after Resident#2's refusal was not addressed.On 03/02/2026 at 12:30 PM after the surveyor's intervention Unit Manager #29 provided documentation to the surveyor to show that Resident #2 was scheduled for an appointment with the facility's dentist on 03/02/2026. |

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|---|---|---|---|
| | 215037 | A. Building<br>B. Wing | 03/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|
| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dispose of garbage and refuse properly.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on observation and staff interview, it was determined that the facility failed to ensure the appropriate maintenance of the exterior trash compactor to prevent the harborage and infestation of pests. This was evident for 1 of 1 exterior trash compactor reviewed during the recertification survey. The findings include:On 02/24/2026 at 10:50 AM, the surveyor evaluated the external dumpster area with the Maintenance Director. The trash compactor was situated at the far end of the open loading dock, approximately 24 feet (equivalent to 2 standard loading bays) from the rear doors of the kitchen and about 6 feet from the central storage room doors where the emergency water supplies were stored. The cemented surfaces surrounding the trash compactor and beneath it were found to be unclean, exhibiting waste leaks and debris. In addition, several wooden pallets were propped against the side wall. The surveyor emphasized the importance of maintaining cleanliness in these areas to avoid the attraction of pests and insect infestations, given the proximity to building entry points. The Maintenance Director acknowledged that the areas would be cleaned, as there were no alternative locations available for relocating the trash compactor.Cross Reference to CMS 2567F 925 |

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|---|---|---|---|
| | 215037 | A. Building<br>B. Wing | 03/03/2026 |

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

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined that the facility failed to maintain infection prevention and control practices. This finding was found to be evident in review of a complaint related to linen availability, usage and storage in the facility during the annual recertification/complaint survey.The findings include: On 2/24/2026 at 12:07 PM the surveyor observed the clean linen cart on the [NAME] Ground Nursing Unit in the hall next to Resident room [ROOM NUMBER]. The clean linen cart was sufficiently stocked with wash clothes and linen, but the clean linen cart was observed uncovered. Two staff members were observed obtaining linen from the uncovered clean linen cart.In an interview with Registered Nurse (RN) employee #14 at 12:12 PM on 2/24/2026 the surveyor asked what the expectation was for the clean linen cart. Employee #14 observed the clean linen cart and proceeded to cover the linen cart with the tan-colored plastic cover that was attached to the clean linen cart and stated that the clean linen cart should have been covered.The facility management was notified of the concern with infection control at the survey exit conference. |

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| | 215037 | A. Building<br>B. Wing | 03/03/2026 |

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

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|---|---|
| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on observation, and staff interview, it was determined that the facility failed to maintain essential equipment in proper operating conditions. This was evident for 3 of 3 pieces of equipment reviewed during the recertification survey.The findings include:All essential kitchen equipment, including but not limited to walk-in coolers, chef base drawer refrigerators, steam tables, dishwashers, convection ovens, stoves, and warming cabinets must be maintained in safe operating conditions in accordance with the manufacturer's specifications and remain accessible throughout kitchen operations. On 02/24/2026 at 8:30 AM, the following kitchen equipment was determined to be nonfunctional according to the manufacturer's specifications:1) The steam table located on the cookline. This unit was being used as a prep table, with steam wells used for storing paper products.2) The Chef Base 4-drawer refrigerator situated on the cookline. Cooking equipment were placed on top of this unit.3) The solid interceptor located beneath the pre-rinse station in the dish machine area. This solid interceptor was leaking greywater directly onto the floor.At 2:45 PM, the Administrator and the kitchen General Manager confirmed that the solid interceptor had been repaired. The surveyor visually verified the functionality of the solid interceptor and a copy of the service report has been requested. |