

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/16/2024
NAME OF PROVIDER OR SUPPLIER  St. Elizabeth Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3320 Benson Avenue Baltimore, MD 21227	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>44440</p> <p>Based on medical record review and interviews with facility staff, it was determined the facility failed to identify the responsible party (RP) and notify them of changes. This was evident for 3 (Resident #382, #66, and #101) out of 57 residents reviewed for resident rights during the facility's annual and complaint survey.</p> <p>The findings include:</p> <p>1. On 10/10/24 at 7:14 AM, the surveyor reviewed Resident # 382's medical record. The review revealed that Resident #382 was admitted to the facility in 2021 and had a past medical history that included, but not limited to, congestive heart failure, hypertension, paroxysmal atrial fibrillation, and altered mental status.</p> <p>Further review revealed on 2/23/24 at 9:35 AM, the Unit Manager, Staff #36 wrote a progress note that stated Resident #382 is alert and oriented with some confusion noted. The note further clarifies that Resident #382 remains his/her own health care decision maker at this time.</p> <p>A decisional capacity evaluation was performed by Psychologist Staff #38 on 3/38/24 at 12:22 PM. The evaluation determined that Resident #382 did not possess sufficient cognitive capacity to make relevant, valid and reliable decisions about health care and or finances. The note further stated Resident #382 however, did have the capacity to appoint an alternate decision maker.</p> <p>On 3/28/24 at 1:53 PM and order was placed for an increase in Resident #382's Semaglutide from 0.25mg injection weekly for diabetes control to 0.5mg injection. The surveyor could not find any notification that the Responsible Party (RP) was notified.</p> <p>A progress note written by Social Service Director Staff #16 on 4/2/24 stated that Resident #382 had a Health Care Agent (HCA) already in place and after Resident #382's capacity evaluation deemed him/her incapable of making healthcare decisions. The note further stated the Attending physician would have to discuss health care decisions with Resident #382's HCA.</p> <p>At the time of exit no documentation was provided that would indicate the RP was notified of the medication increase.</p> <p>47758</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an interview on 10/04/2024 at 8:12 AM, Resident #66's daughter stated she is the RP and the facility changed her mother's medications without discussions or notifications.</p> <p>A record review on 10/04/24 at 09:34 AM, did not reveal notification to the RP. The surveyor requested the facility provide notification to the RP of medication changes for Aricept.</p> <p>On 10/04/24 at 11:23 AM, the Administrator and 2nd Floor Unit Manager reported they were not able to find notification to Resident #66's RP for Aricept changes. The Administrator acknowledged the concern about lack of notification to the RP.</p> <p>3. On 10/7/24 at 1:02 PM, the surveyor received an email from Resident's #101's RP that there was no notification that Remeron was started. The surveyor did not find documentation in a record review and requested the facility provide documentation.</p> <p>During an interview on 10/09/2024 at 8:28 AM, the Assistant Director of Nursing (ADON) stated that no notification was found that Resident #101's RP was notified that Remeron was being ordered. The ADON stated that when medication changes are considered the expectation is that we discuss medication changes with the RP and make sure they agree. If we leave a message we still need to call back and discuss the changes. She further stated the facility discussed the importance of notifications to the RP with the Medical Director, and providers in the group were notified of this.</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>44440</p> <p>Based on medical record review and interviews it was determined that the facility failed to inform in advance of treatment changes. This was found evident for 1 (Resident #382) out of 18 residents reviewed for rights during the complaint portion of the annual survey.</p> <p>The findings include:</p> <p>On 10/10/24 at 7:14 AM, the surveyor reviewed Resident # 382's medical record. The review revealed that Resident #382 was admitted to the facility in 2021 and had a past medical history that included, but not limited to, congestive heart failure, hypertension, paroxysmal atrial fibrillation, and altered mental status.</p> <p>On 2/23/24 at 9:35 AM, the Unit Manager Staff #36 wrote a progress note stated Resident #382 is alert and oriented with some confusion noted. The note further clarifies that Resident #382 remains his/her own health care decision maker at this time.</p> <p>The surveyor next reviews an order written on 3/7/24 for a new medication Semaglutige 0.25mg injection weekly for diabetes control. The surveyor was unable to find documentation in the medical record that Resident #382 was informed that a new medication was being started or the possible side effects. However, on 3/12/24 a progress note was written that stated that Resident #382 was informed of his/her laboratory results and updated on the start of a different medication.</p> <p>The surveyor noted that even after Resident #382's medical team visited with Resident #382 on 3/15/24, there was no mention of the new medication or that Resident #382 was updated on changes to the plan of care.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>49148</p> <p>Based on record review and interviews with the residents and staff, it was determined that the facility failed to answer call bells timely to attend to the needs of dependent residents. This was evident for 3 (Resident # 81, #106, and #382) out of 6 residents call history reports reviewed during the annual and complaint survey.</p> <p>The findings include:</p> <p>1. On 9/30/2024 at 1:30PM, the Surveyor conducted an interview with roommates, Resident #81 and Resident #106 in their room. An interview with Resident #81 revealed that the resident had to wait over an hour last week for staff to answer the call bell and address his/her needs.</p> <p>On 9/30/2024 at 1:35PM, the Surveyor conducted an interview with Resident #106. The resident informed the Surveyor that one night last week, he/she used the call bell for assistance with incontinent care and had to sit and wait for hours before his/her needs were addressed.</p> <p>During an interview conducted with Nursing Home Administrator (NHA) #1 on 10/3/2024 at 7:43AM, the Surveyor was informed that when a resident uses the call bell, the call will be transmitted to all call system monitor screens located on each unit near the Unit Managers offices, there is a pager system that alerts the nursing staff, and a green light illuminates outside the residents door to let the staff know who needs assistance. Call bells should be answered within 10 minutes, anything longer than that would be unacceptable. Once staff has responded to the residents' call, the nursing staff should turn off the call bell.</p> <p>On 10/03/2024 at 8:00AM, during a review of call history reports from 9/01/2024 through 10/01/2024 for Resident #81's and Resident #106's room, the Surveyor discovered call times on 9/18/2024 at 6:56PM with a wait time of 1 hour, 9/21/2024 at 8:44AM with a wait time of 42 minutes, 9/21/2024 at 11:16AM with a wait time of 1 hour, 9/21/2024 at 12:55PM with a wait time of 2 hours, 9/22/2024 at 7:38PM with a wait time of 1 hour, and 10/1/2024 at 3:16PM with a wait time of 41 minutes.</p> <p>During a review of the facilities procedure for Answering the Call Light, the Surveyor discovered that all staff are to ensure timely responses to the resident's requests and needs.</p> <p>On 10/11/2024 at approximately 11:00AM during an interview conducted with NHA #1, the Surveyor confirmed that Resident #81's and Resident #106's call bell was not answered according to expectation on 9/18/2024, 9/21/2024, 9/22/2024, and 10/1/2024. NHA #1 stated that call bell audits are done every morning. Call bell follow-up sheets are completed by the Unit Managers to address the call bells that were not answered according to the expectation of 10 minutes.</p> <p>A review of the Call Bell Follow-up sheets for 9/18/2024 at 6:56PM, 9/21/2024 at 11:16AM, and 10/1/2024 at 2:35PM revealed that the nursing staff did not have their pagers at the time the call bell was activated.</p> <p>44440</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 10/9/24 at 7:58 AM, the surveyor reviewed intake MD00202308. The intake described that Resident #382 had a call light unanswered during the evening into morning shift. The intake stated that the same morning Resident #382 was later discovered to have had a medical emergency.</p> <p>Next the surveyor reviewed the progress notes and discovered that Resident #382 was sent to the hospital for a medical emergency on 2/4/24.</p> <p>On 10/9/24 at 12:06 PM, the surveyor requested the call bell log response log for Resident #382's room from 2/3/24 through 2/4/24.</p> <p>On 10/11/24 at 2:19 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA) #1. During the interview the surveyor showed the NHA #1 that on 2/4/24 at 7:01 AM a call light from Resident #382's room was put on and the log revealed it was canceled at 8:09 AM, this was over an hour. The NHA #1 agreed that the response time was unacceptable.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47758</b></p> <p>Based on observations, interviews and record reviews, it was determined that the facility failed to maintain clean carpets. This was found to be evident in many carpeted areas of the facility.</p> <p>The findings include:</p> <p>On 09/30/24 at 08:38 AM, the surveyor walked into room [ROOM NUMBER] and observed that the floor was sticky, and shoes were sticking to the carpet.</p> <p>During an observation on 10/01/24 at 09:19 AM, the surveyor noted sticky carpet in room [ROOM NUMBER].</p> <p>During an interview with the Maintenance Director on 10/4/24 at 02:03 PM, the surveyor asked about the sticky carpets and floors. The Maintenance Director replied that the floors get sticky when staff use too much cleaning solution ratio to water. He later provided a Staff Education sign in sheet where employees were educated on proper dilution of chemicals to water for floor cleaning.</p> <p>A record review of the facility web based work orders from Technology Enhanced Learning and Science (TELS) log on 10/10/24 at 08:50 AM, revealed many requests for carpet cleaning by staff.</p> <p>On 10/10/24 at 9:45 AM, a complainant told the surveyor that the carpet in room [ROOM NUMBER] was sticky, dirty and needed to be replaced when Resident #381 was there in April of 2023. Another complainant for Resident #379 stated that the carpet was dirty in room [ROOM NUMBER] in 2023.</p> <p>During an interview on 10/10/24 at 11:00 AM, the Nursing Home Administrator (NHA) #1 acknowledged the carpet concerns and stated the facility is planning to replace the carpet during the upcoming renovations.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47758</p> <p>Based on facility investigations, record reviews, interviews, and observations, the facility failed to protect residents from abuse and neglect. This was found to be evident for 2 (Resident #41 and #47) out of 12 residents investigated during for abuse and neglect during the annual and complaint survey.</p> <p>The findings include:</p> <p>During a review of intake #MD00205837 on 10/06/2024 at 1:24 PM, the facility had reported on 5/16/24 that Resident #63 was observed hitting Resident #47 in the face. The facility sent Resident #63 to the hospital for emergency evaluation of behaviors and possible changes to medications.</p> <p>On 10/06/2024 at 1:24 PM, the surveyor reviewed a facility reported incident #MD00205828, dated 5/18/24, that reported Resident #41 was kicked in the face by Resident #63. No injuries were noted, and the residents were immediately separated.</p> <p>During an interview with the Director of Nursing (DON) #2 on 10/07/2024 9:29 AM, the surveyor was told that when Resident #63 first arrived at the facility there had a lot of adjustment problems managing her behavior. Resident #63 has involuntary movements based on his/her condition.</p> <p>An Emergency Petition was obtained, and Resident #63 was transferred to the hospital for emergency psychiatric care. The facility was unable to place her into another facility until her behavior could be managed and Resident #63 was closely monitored and kept away from other residents.</p> <p>The DON #2 acknowledged that all residents have the right to be free from abuse and failure to protect the residents from abuse was a concern.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>49148</p> <p>Based on review of a facility reported incident and interview with staff, it was determined that the facility failed to report the results of an alleged abuse investigation within five working days to the Office of Health Care Quality. This was evident for 4 (Resident #375, #29, #72, and #223) out of 12 residents investigated for abuse during the annual and complaint survey.</p> <p>The findings include:</p> <p>1. On 10/9/2024 at 8:58AM, the Surveyor reviewed Resident #375's facility reported incident of alleged abuse which occurred 11/28/2023.</p> <p>Additional review of the facility reported incident revealed that the facility initiated an investigation and submitted a self-report on 11/29/2023 to the Office of Health Care Quality. The final investigation report was completed and submitted to the Office of Health Care Quality on 12/12/2023.</p> <p>On 10/10/2024 at 1:15PM, the Surveyor conducted an interview with the Director of Nursing (DON) #2 and confirmed that the final investigation report was not submitted to the Office of Health Care Quality within five working days of the incident.</p> <p>42828</p> <p>2. On 10/03/24 at 1:30 PM surveyor review of the facility reported incident MD0020597 revealed that, on 5/21/24 Residents #29, #72 and #223 alleged that a staff member geriatric nursing assistant (GNA), Staff #24, was verbally abusive and rough with them while receiving assistance with cares.</p> <p>Review of the facility investigation revealed that the facility submitted the initial report to the Office of Health Care Quality (OHCQ) on 5/22/24 within 24 hours of the allegation as required. However, the final report was not submitted to the OHCQ until 5/31/24. The facility is required to complete the final investigation and submit the final report within 5 working days.</p> <p>On 10/4/24 at 11:20 AM the surveyor conducted an in-person interview with the Director of Nursing (DON) #2 and Unit Manager (UM) #23, to share the concerns that the final report related to MD0020597 was not received within five working days of the initial report. The DON #2 confirmed that she was aware of the late submission.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>44440</p> <p>Based on record review, review of facility investigation, and interviews it was determined that the facility failed to suspend a staff member and prevent potential abuse while an abuse investigation was still being conducted. This was found evident of 1 (Resident #385) out of 12 Residents reviewed for abuse.</p> <p>The findings include:</p> <p>On 10/3/24 at 8:03 AM, the surveyor reviewed Resident #385's medical record. The review revealed a note written on 8/6/24 by Unit Manager (UM) #36 that described Resident #385's Responsible Party (RP) wanted to report that he was informed by a family member that his mom/dad alleged they were beaten up by the staff.</p> <p>Next the surveyor reviewed the facility's investigation into the incident. After interviews, review of Resident #385's assessments and statements, the facility was unable to substantiate the allegation.</p> <p>On review of the Geriatric Nursing Assistance (GNA) #37 employee file, there was no indication the GNA #37 was suspended.</p> <p>On 10/8/24 at 1:42 PM, the surveyor interviewed the Director of Nursing (DON). When asked if the alleged GNA #37 was suspended during the investigation, the DON stated the GNA #37 was only reassigned and however, did not work with Resident #385. The DON stated she should have suspended GNA #37 until the investigation was complete.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>44440</p> <p>Based on review of medical records, review of correspondences, and interviews with staff, it was determined that the facility failed to have complete, appropriate documentation in the medical record to ensure the discharge needs of a resident were met. This was found evident of 1 (Resident #390) of 3 Residents reviewed for discharges.</p> <p>The findings include:</p> <p>On 10/9/24 at 7:26 AM, the surveyor reviewed Resident #390 ' s medical record. The review revealed Social worker Staff #18 wrote a progress note on 6/28/24 stating that Resident #390 was anticipating returning home with his/her daughter. If further stated that home health equipment had been assessed and the current needed equipment was delivered to the Resident ' s home. The note concludes by stating that Resident #390 will be receiving home health services from an outside company that will include, home health Physical Therapy (PT), Occupational Therapy (OT), Home Nurse, Social Work and Home Health Aide.</p> <p>The discharge information was written in the Resident ' s interdisciplinary team (IDT) discharge form. Home Health Physical Therapy (PT), Occupational Therapy (OT), Home Nurse, Social work and Home Health Aide were all checked to indicate the resident would be receiving the services on discharge. The document was signed by the resident on 6/30/24.</p> <p>The surveyor reviewed the discharge recommendation from OT. The recommendations stated that Resident #390 should receive caregiver assist from family and home health services additionally which includes OT. The PT discharge recommendations recommend home health PT to progress towards his/her prior level of function and ensure safe transition home. Both of these notes were signed on 7/1/24.</p> <p>On 6/30/24 a discharge note was written that stated Resident #390 verbalized understanding of the discharge and a copy of the IDT discharge form was given to the Resident.</p> <p>On 7/3/24 a follow up progress note was written by Staff #18 that documented the home health agency contacted the facility and stated the physician notes reviewed did not reflect the need for home health care and that the notes would need to be revised in order for home health to start for Resident #390</p> <p>On 7/8/24 Staff #18 wrote a note that stated the home health agency receive the updated note and would be contacting Resident #390 ' s daughter. This was 8 days after the resident was discharged .</p> <p>(continued on next page)</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/11/24 at 9:17 AM, the surveyor interviewed Staff #18. During the interview Staff #18 stated that she had set up home health services on 6/28/24 which was a Friday and that the Resident #390 was discharged that Sunday 6/30/24. She further stated she received an email from the home health agency on 7/2/24 asking for clearer documentation to support home care from the provider. Staff #18 stated she emailed the providers on that same day asking them to clarify their notes to indicate the need for home health. Staff #18 provided the email correspondence. She next stated that after not getting a response from the providers she forwarded the request to the Nursing Home Administrator (NHA). In the email correspondents dated 7/8/24 the NHA sends an email to the home health agency that stated Resident #390 's family was reporting to the facility that the home health care services have not yet started. The NHA asked the home health agency to validate/clarify if home health care services were started. Next the home health agency replies that they are still waiting for clarification from the provider. The follow up email is from the NHA to the home health agency and has an attached progress note with the providers addendum that was requested on 7/2/24.</p> <p>On 10/11/24 at 1:23 PM, the surveyor conducted an interview with the NHA. During the interview the surveyor brought up the concerns that due to incomplete documentation and delay in updating documentation a resident that was discharged with needs for home health service did not receive the services for over a week. The NHA agreed that there was a delay in providing the discharge needs for Resident #390.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42828</b></p> <p>Based on medical record reviews and interviews, it was determined that 1) the facility staff failed to maintain supervision of a resident to minimize the risk for falls. This was evident for 1 (Resident #224) out of 9 residents reviewed for accidents during the annual survey. 2) The facility staff failed to provide treatments according to a Resident ' s plan of care. This was found evident of 1 (Resident #382) out of 4 residents reviewed for pressure ulcers.</p> <p>The findings include:</p> <p>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.</p> <p>On 10/09/24 at 9 AM, review of complaint MD00192468 revealed that on 10/19/22, Resident #224 sustained a fall when left unsupervised in the shower room.</p> <p>A review of Resident #224's medical record was done on 10/09/24 at 9:30 AM. The review revealed that the resident was admitted to the facility on [DATE] with diagnoses including dementia, impaired balance, history of falls and limited mobility. Further review of the resident's medical record showed a care plan related to his/her self- care performance deficit that determined the resident required assistance by (1) staff with bathing/showering.</p> <p>On 10/10/24 at 11 AM review of the facility's policy and procedures titled Bath, Shower/Tub under subsection General Guidelines, read: Stay with the resident throughout the bath. Never leave the resident unattended in the tub or shower.</p> <p>An ongoing record review revealed a physician communication form (SBAR) that had been completed by nursing staff on 10/19/22 which revealed that Resident #224 had an unwitnessed fall and was found in the bathroom after falling from a broken shower chair. The resident had not sustained any visible injuries, however orders for an x-ray of Resident #224's back were ordered. The results from the the x-rays done on 10/20/22 of Resident # 224's back revealed there were no fractures.</p> <p>During an interview with the Director of Nursing (DON) on 10/10/24 1:48 PM the surveyor asked what happened to Resident #224' s on 10/19/22. The DON stated she reviewed the SBAR dated 10/19/22 and determined the resident fell due to a broken shower chair and the resident was found on the floor. She audited all shower chairs in use in the facility and found that broken shower chair was the only one that was broken. The DON went on to say, That shower chair had not been noted to be broken before that incident. Sometimes staff do not report broken equipment, the expectation is that the staff are to put in a request to the maintenance staff as soon as broken equipment is identified as unusable, remove it from the resident care area, and staff are to notify their charge nurse immediately.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/16/2024
NAME OF PROVIDER OR SUPPLIER  St. Elizabeth Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3320 Benson Avenue Baltimore, MD 21227	
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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Later during the interview, the surveyor asked why the resident was found on the floor and the incident listed as an unwitnessed fall, the DON replied, I do not know. It is our policy that staff are not to leave any residents unattended during baths/showers. The incident was investigated as a broken shower chair and not as a lack of supervision. I overlooked that part. I immediately had the shower chair removed and conducted an in-house audit of all shower chairs, then ordered new shower chairs. The surveyor expressed the concern that the resident was unsupervised and sustained an unwitnessed fall when the resident required (1) person assistance for bathing/showers.</p> <p>10/11/24 1:30 PM the DON confirmed that on 10/19/22, Resident #224 sustained an unwitnessed fall, and the resident was not to be left alone during showers/baths. The surveyor relayed the concern that there was a lack of supervision for a resident who was assessed and care planned for needing assistance during showers/baths was made to the DON and the Nursing Home Administrator (NHA).</p> <p>44440</p> <p>The findings include:</p> <p>On 10/10/24 at 7:14 AM, the surveyor reviewed Resident # 382 ' s medical record. The review revealed that Resident #382 was admitted to the facility in 2021 and had a past medical history that included, but not limited to, congestive heart failure, hypertension, paroxysmal atrial fibrillation, diabetes, and left foot open wound.</p> <p>The surveyor further reviewed the Treatment Administration Record (TAR) for Resident #382 for the month of November 2023, December 2023 and January 2024. Resident #382 had multiple treatments ordered for different locations. On November 6th Resident #382 had eight treatment orders for wound care. Only one (location on the coccyx) was documented as completed and all other 7 sites were left blank. The days that Resident #382 refused were documented with a refusal comment. On review of the December 2023 TAR the coccyx wound treatment was left blank on 12/4/23, 12/14/23, 12/15/23, 12/18/23, 12/22/23, 12/23/24 and 12/24/23. The wound treatment for the left lower leg and right heel were left blank on 12/2/23 and 12/12/24. The days that Resident #382 refused were documented with a refusal comment. The January 2024 TAR revealed the coccyx wound was left blank on 1/1/24, 1/2/24, and 1/8/24 and 1/30/24. The wound treatment for the right heel was left blank on 12/14/24. The days that Resident #382 refused were documented with a refusal comment.</p> <p>On 10/10/24 at 9:18 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON confirmed that when a dressing change is completed it should be documented in the TAR. She confirmed that the multiple times the resident refused the dressing treatment it was documented appropriately in the progress notes. The DON was not able to explain why several of the dressing changes were left blank. She agreed that without it being documented as completed it appeared that the dressing was not changed as ordered.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>44440</p> <p>Based on observation, medical record review, review of the facility's investigation reports, and interviews with staff, it was determined that the facility failed to supervise and provide a secure environment for a resident residing in a secure unit. These failures contributed to the resident eloping and placed the resident at increased risk for serious harm. This was evident for 1 (Residents #374) of 3 residents reviewed for elopement. The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Immediate Jeopardy Past Non-compliance.</p> <p>The findings include:</p> <p>On 10/4/24 at 9:18 AM, the surveyor reviewed the medical record for Resident #374. The review revealed that Resident #374 was admitted to the facility in late 2020 and had a past medical history that included, but was not limited to, vascular dementia , and other abnormalities of gait and mobility.</p> <p>The surveyor reviewed the care plans for Resident #374. A care plan initiated on 11/30/20 stated, that Resident #374 has a diagnosis of dementia and presents with memory impairments. Listed as an intervention was; cue, reorient and supervise as needed. On 12/8/20 an additional care plan was initiated that stated, Resident is an elopement risk/wanderer and exhibits exit seeking behaviors related to vascular dementia; disoriented to place, impaired safety awareness, resident wanders aimlessly and significantly intrudes on the privacy or activities of others. On 5/13/22 a care plan was initiated that stated Resident #374 had a behavior problem related to unspecified dementia. On 1/20/23 Resident #374 had another care plan added that stated, Resident has poor safety awareness related to cognitive function/dementia or impaired thought processes, dementia, impaired cognitive function, impaired decision making. Interventions for this care plan listed to check frequently on the Resident when in his/her room and ensure orders for safety precautions are in place.</p> <p>On further review, the surveyor noted that there were several progress notes written regarding Resident #374's wandering and inappropriate behaviors. On 5/20/22 a progress note was written by Certified Registered Nurse Practitioner in Psychiatric Mental Health (CRNP-PMH) Staff #34, that stated, Resident #374 lacked judgment and insight regarding everyday activities. A progress note written by the Social Service Staff #34 on 6/9/23 stated Resident #374 continues to wander on the secure unit. The note further stated that staff will continue to provide redirection as needed.</p> <p>The surveyor next reviewed a progress note dated 6/23/23, that described an event where Resident #374 exited the patio gate with his/her walker and walked through the grass, down the hill, to the hospital. The note further stated that Resident #374 was returned to the unit by the Unit Manager and an assessment was completed with no injuries noted.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/4/24 at 11:01 AM, the surveyor reviewed the facility's investigation file. The review revealed that Resident #374 was attending an outdoor activity on the patio. The patio was attached to the locked unit. During the activity, the activity staff was assisting another resident, at which time it was determined that Resident #374 was able to open the gate to the enclosed patio and leave the gated area. The hospital notified the facility at 2 PM, that Resident #374 was located at the hospital and at 2:10 PM Resident #374 was returned to the facility. The report further concluded that the locking mechanism to the gate was open and disarmed due to a fire drill that was conducted the day before.</p> <p>On 10/7/24 at 8:15 AM, the surveyor observed the courtyard connected to the secured unit. The gate was secured and there was no ability for a Resident to leave the gated courtyard. The hospital ' s parking lot was able to be seen from the courtyard. To get there a person would have to walk down a grassy hill which would lead you to the parking area connected to the hospital.</p> <p>On 10/07/24 at 9:29 AM, the surveyor interviewed the Activities Assistant Staff #28, who was working with residents in the locked unit. During the interview, Staff #28 stated that she had just started the job a few weeks ago and due to the constant rain, no activities had been held into the courtyard. When asked what the protocol was for activities conducted in the courtyard staff #28 stated that the activities person should first check the gate to make sure it is locked. She further stated she and an additional person would obtain a census for the residents that were scheduled to attend the activity and would take attendance before and after the activity. She stated that two people were required to supervise the residents.</p> <p>On 10/7/24 at 2:02 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated the facility staff that supervised the outdoor activity when Resident #374 eloped was no longer working at the facility. She further stated while investigating the incident it was determined that the gate within the enclosed fence that surrounded the patio was unlocked due to a fire drill that was conducted the day before. The DON stated that education was provided to activities staff and nursing on the protocol for activities conducted on the patio. Also, she stated that education was provided to the maintenance staff that included checking the gate after all fire drills and/or power outages.</p> <p>On 10/10/24 at 7:30 AM, the surveyor interviewed the Maintenance Manager Staff #12. During the interview Staff #12 stated that after the elopement incident with Resident #374, his staff were educated on the protocol to check the magnetic locks after every fire drill or power outage.</p> <p>On 10/10/24 the surveyor reviewed the corrective action the facility provided to the surveyor. An in-service was completed on 6/23/23 with the maintenance staff that included the education training to check all exits after fire drills. An in-service was completed for staff on the protocol for resident safety during outside activities on the locked unit. The education included: 1. directions to split up residents into two different groups with two staff members. 2. Activity and nursing staff to check the gate prior to outside activities to ensure that it ' s locked during activities. 3. Collaboration with nursing staff with a roll call at the beginning of an activity and the end of an activity to make sure all the residents are accounted for. 4. Activity staff and nursing staff have been educated on the steps to protect our patients from leaving the facility unaccompanied during outside therapeutic activities. This education was completed on 6/26/23. The facility was in substantial compliance as of 6/26/2023.</p>		