STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215044	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Elizabeth Rehabilitation & Nursing Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility failed to ensure that refrigerated food items were consistently labeled and dated with preparation and expiration dates to maintain sanitary storage conditions and prevent the potential for serving unsafe food. This deficient practice was identified during the initial and follow-up tours of the kitchen during the recertification survey. The findings include: On 02/19/2026 at 7:52 AM, during the initial tour of the kitchen, the surveyor met with Dietary Technician (Staff #32). At 8:03 AM, during observation of the walk-in refrigerator identified by Staff #32 as grocery storage, the surveyor observed eight bags of cabbage without labels or dates, one mixed tray of carrots and cabbage that was unlabeled and undated, two trays of sliced tomatoes without labels or dates, and two bags of carrots with a Best Used By January 27, 2026 date. When interviewed, Staff #32 stated that unlabeled groceries were usually prepared the same day or the day before and acknowledged that they should have been dated. Regarding the cabbage, he stated it was supposed to have an expiration date. When informed that the carrots were past the Best Used By date, he stated it was an oversight and that the items would be removed.On 02/19/2026 at 8:15 AM, the Lead [NAME] (Staff #21) met with the surveyor and Staff #32 in front of the walk-in refrigerator and was asked for dual observation. Staff #21 confirmed that the items had no labels or dates and stated that the items would be discarded. The items were then removed from the refrigerator.On 02/25/2026 at 12:57 PM, during a follow-up visit to the kitchen with the Certified Dietary Manager (CDM), the surveyor again observed two unlabeled and undated bags of carrots in the grocery refrigerator. The surveyor also observed two trays of tuna fish and one tray of sliced tomatoes stored in another refrigerator without labels or dates. The CDM acknowledged the findings and stated the items would be removed immediately.On 02/26/2026 at 7:49 AM, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) were informed of the concerns identified during the kitchen tours. Both acknowledged the findings.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, it was determined that the facility failed to provide respiratory care services for residents that meets professional standards. This was evident for 6 residents (Resident #161, #121, #162,#118, #160, and #2) out 9 reviewed for respiratory services during the annual survey. The findings Include:1) On 02/19/2026 at 9:29 AM, during the initial tour of the facility, Resident #161 was observed lying in bed receiving oxygen via nasal cannula. The oxygen concentrator was set at 4.5 liters per minute (LPM). On 02/19/2026 at 11:30 AM, review of the resident's electronic health record (EHR) revealed no active physician order for oxygen therapy or oxygen flow rate. An order dated 02/18/2026 stated: Change, Date & Initial O2 tubing & Humidifier bottle weekly & PRN every night shift every Wed for Infection Prevention. No order specifying oxygen flow rate was identified at that time. On 02/19/2026 at 1:35 PM, review of the hospital Discharge summary dated [DATE] revealed the resident was discharged on 3 LPM of oxygen. On 02/19/2026 at 1:47 PM, an interview was conducted with Licensed Practical Nurse (LPN #12). When asked what the ordered oxygen flow rate was for Resident #161, LPN #12 stated the resident was receiving 2 LPM. When asked when the order was obtained, she stated that the outgoing nurse had reported during shift report that the resident was on 2 LPM. When asked who entered the oxygen order into the EHR, LPN #12 reviewed the record and stated there was no physician order for oxygen. She further stated there should have been an order specifying the oxygen flow rate. On 02/19/2026 at 1:50 PM, during dual observation with LPN #12, the oxygen concentrator was observed set at 4.5 LPM. LPN #12 adjusted the oxygen flow rate to 2 LPM at that time. On 02/19/2026 at 1:57 PM, an interview was conducted with the Unit Manager (LPN #10). When asked what the prescribed oxygen flow rate was for Resident #161, she stated it should be reflected in the physician orders. After reviewing the EHR, she confirmed there was no oxygen flow rate order present in the resident's record. She stated the order should have been entered, as oxygen was noted in the hospital discharge summary. At that time, LPN #12 informed the Unit Manager that she did not locate an order and did not further investigate because she relied on shift report indicating the resident was receiving 2 LPM. On 02/20/2026 at 9:03 AM, follow-up review of the resident's physician orders revealed a new order stating: Oxygen at 3 LPM via nasal cannula continuous every shift. Notify provider if oxygen saturation is less than 90%. On 02/20/2026 at 9:31 AM, follow-up observation of Resident #161 revealed the oxygen concentrator was set at 4 LPM. On 02/20/2026 at 9:51 AM, during a dual observation with Registered Nurse (RN #13), the oxygen was confirmed to be running at 4 LPM. When asked what the prescribed oxygen flow rate was, RN #13 stated the resident had shortness of breath and she had been informed during shift report that the resident was to receive 4 LPM. When asked to verify the physician order, she reviewed the EHR and stated the order was for 3 LPM. RN #13 then adjusted the oxygen flow rate to 3 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/20/2026 at 10:02 AM, a follow-up interview was conducted with the Unit Manager (LPN #10). When asked about the process for shift-to-shift reporting, she stated outgoing nurses were responsible for providing accurate information regarding residents' needs and treatments. When informed that Resident #161 had been receiving 4 LPM based on shift report despite a 3 LPM physician order, she acknowledged that the error involved inaccurate reporting by outgoing nurses and failure of incoming nurses to verify physician orders. She stated nursing staff would receive in-service education regarding verification of physician orders. 02/24/2026 10:52 AM in an interview with the DON, when asked for expectations regarding oxygen flow rates, she stated that there had to be a physician order in place which is expected to be followed by the nurses. On 02/24/2026 at 11:01 AM, when concerns regarding the absence of oxygen orders and the administration of incorrect oxygen flow rates were discussed with the DON, she acknowledged it as a concern. 2) On 02/19/2026 at 8:59 AM, during the initial tour of the facility, Resident #121 was observed receiving oxygen at 3 liters per minute (LPM) via nasal cannula. The oxygen tubing in use was not dated or labeled to indicate when it had last been changed. On 02/20/2026 at 9:39 AM, a follow-up observation of Resident #121 revealed the resident continued to receive oxygen at 3 LPM via nasal cannula. The oxygen tubing remained undated and unlabeled. The attached humidifier bottle was observed to be empty. On 02/20/2026 at 9:42 AM, Licensed Practical Nurse (LPN #15) participated in a dual observation and confirmed that the oxygen tubing was not dated or labeled and that the humidifier bottle was empty. When asked when the tubing had last been changed, LPN #15 stated she did not know due to the absence of a date on the tubing. When asked about the facility's expectation regarding oxygen tubing maintenance, LPN #15 stated that the tubing should be dated and labeled after each change. LPN #15 stated she would replace the tubing and humidifier bottle immediately. 3)On 02/20/2026 at 1:14 PM, Resident #162, identified as a new admission, was observed receiving oxygen at 2 LPM via nasal cannula. Observation of the oxygen tubing did not reveal any date or labeling indicating when the tubing had been changed. On 02/24/2026 at 9:10 AM, a follow-up observation in Resident #162's room revealed the oxygen tubing remained undated and unlabeled. On 02/24/2026 at 9:16 AM, LPN #15 was called for dual observation and confirmed that the oxygen tubing was not dated or labeled. LPN #15 stated that it should have been dated and labeled and indicated she would do so immediately. On 02/24/2026 at 10:50 AM, during an interview, the Director of Nursing (DON) was asked about the facility's expectation regarding the dating of oxygen connecting tubing. The DON stated that oxygen tubing should be changed and dated weekly on Wednesdays and as needed. On 02/24/2026 at 11:01 AM, when concerns regarding the absence of oxygen orders and the administration of an incorrect oxygen dose were discussed with the DON, she acknowledged it as a concern. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 02/19/2026 at 9:11 AM, during the initial tour of the facility, Resident #118 was observed receiving oxygen via a nasal cannula. The oxygen tubing was not dated or labeled to indicate when it had been changed. On 02/20/2026 at 9:40 AM, a follow-up observation of Resident #118 revealed the resident continued to receive oxygen via nasal cannula. The oxygen tubing was still not dated and labeled. On 02/20/2026 at 9:43 AM, Licensed Practical Nurse (LPN) #9 was brought into Resident #118's room and shown that the oxygen tubing was not labeled. He stated that the oxygen tubing should be changed weekly depending on the order and that the oxygen tubing should have been labeled and dated after it was changed. On 02/20/2026 at 9:44 AM, During an Interview with the 3rd floor Unit Manager, she stated and confirmed that oxygen tubing should be changed weekly and that after the staff changed the tubing they are expected to label and date the tubing. At this time she was made aware of the concern. 5) On 02/19/2026 at 9:19 AM, during the initial tour of the facility, Resident #160 was observed receiving oxygen via a nasal cannula. The oxygen tubing was not dated or labeled to indicate when it had been changed. On 02/20/2026 at 9:40 AM, a follow-up observation of Resident #160 revealed the resident continued to receive oxygen via nasal cannula. The oxygen tubing was still not dated and labeled. On 02/20/2026 at 9:43 AM, Licensed Practical Nurse (LPN) #9 was brought into Resident #160's room and shown that the oxygen tubing was not labeled. He stated that the oxygen tubing should be changed weekly depending on the order and that the oxygen tubing should have been labeled and dated after it was changed. On 02/20/2026 at 9:44 AM, During an Interview with the 3rd floor Unit Manager, she stated and confirmed that oxygen tubing should be changed weekly and that after the staff changed the tubing they are expected to label and date the tubing. At this time she was made aware of the concern. 6a) On 02/19/2026 at 8:21 AM, an observation in Resident #2's room revealed that his/her oxygen was set at 2 liters of oxygen. The surveyor asked Resident #2 what his/her oxygen is supposed to be set at, and Resident #2 stated that it was supposed to be at 3 liters. On 02/19/2026 at 8:26 AM, during an interview with Licensed Practical Nurse (Staff #8) he/she asked Resident #2 what his/her oxygen should be set at, and Resident #2 stated 3 liters and Staff #8 then proceeded to adjust the flow rate to 3 liters. On 02/26/2026 at 10:13 AM, record review revealed that Resident #2 had an active physician's order for oxygen at 3 liters. 6b) On 02/19/2026 at 8:21 AM, an observation in Resident #2's room revealed that his/her oxygen tubing was unlabeled. On 02/19/2026 at 8:26 AM, an interview with Licensed Practical Nurse (Staff #8) revealed that the expectation was that the oxygen tubing should have been labeled. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/20/2026 at 9:38 AM, a second observation in Resident #2's room revealed that his/her oxygen tubing remained unlabeled. On 02/20/2026 at 9:45 AM, an interview with Registered Nurse (Staff #16) revealed that the expectation was that the oxygen tubing should have been labeled. On 02/20/2026 at 11:44 AM, a third observation in Resident #2's room revealed that his/her oxygen tubing was labeled. On 02/24/2026 at 9:03 AM, the concerns were brought up with the Director of Nursing and she indicated that she understood.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure that food was served to residents at an appropriate and palatable temperature to ensure quality and safety. This deficient practice was identified during test tray observation on 1 (second floor) out of 2 floors during the facility's recertification survey.The findings include:On 02/19/2026 at 8:40 AM, during an interview, Resident #63 reported that food was consistently cold when delivered to his/her room.On 02/19/2026 at 9:50 AM, during an interview, Resident #92 stated that meals were cold and stale upon delivery.On 02/24/2026 at 11:09 AM, the surveyor conducted an observation of the lunch tray line for the first floor. Dietary Aide Staff #19 was observed plating meals for residents dining in the main dining room.On 02/24/2026 at 11:44 AM, the surveyor inquired regarding the service schedule for residents who preferred to dine in their rooms. Dietary Aide Staff #19 stated that she would begin preparing those trays only after completing meal service for residents in the dining room.On 02/24/2026 at 11:52 AM, the first meal cart departed the dining room for the unit.On 02/24/2026 at 12:39 PM, as the final meal cart was being prepared, the surveyor requested that the Certified Dietary Manager (CDM) include a test tray on the final cart designated for the first floor.On 02/24/2026 at 12:41 PM, the final meal cart departed from the dining room. The surveyor and the CDM followed the cart to the unit to conduct a test tray observation. The cart was parked in the hallway while the Administrator-in-Training and the Geriatric Nursing Assistant (GNA) transported trays from the cart to residents' rooms. The final tray was delivered at 12:49 PM.On 02/24/2026 at 12:50 PM, the CDM tested the food on the test tray using the facility's food thermometer. The recorded temperatures were as follows: peanut butter pie, 72.2 F; cola-glazed ham, 104.4 F; baked sweet potato, 113 F; green beans, 116 F; and carrots, 117 F.When he/she was asked regarding the facility's expected food temperatures, the CDM stated that hot food items were required to be served between 125 F and 135 F, and cold food items at 41 F or below. When he was informed of the concern regarding the recorded food temperatures, the CDM acknowledged the concern.On 02/25/2026 at 12:49 PM, the concern with the food temperature for residents on the second floor was presented to the Nursing Home Administrator (NHA) and the Director of Nursing (DON).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to ensure that residents and/or their representatives were provided with written notice of hospital transfer and information regarding the facility's bed-hold policy. This was found evident for 2 (Residents #14 and #5) out of 2 residents reviewed for hospitalization during the facility's recertification survey. The findings include: On 02/23/2026 at 12:59 PM, review of Resident #14's electronic health record revealed that the resident was transferred to the hospital on [DATE] with diagnoses of anemia and altered mental status.On 02/23/2026 at 1:58 PM, a review of the resident's clinical record was conducted to determine whether the facility had provided and documented written notice of the hospital transfer and the facility's bed-hold policy to the resident and/or responsible party. The record did not contain documentation of a notice of transfer.On 02/23/2026 at 2:40 PM, review of Resident #5's electronic health record revealed that the resident was discharged to the hospital on [DATE] due to acute respiratory failure with hypoxia. Documentation indicated the resident had experienced repeated hospitalizations for pneumonia and hypoxia.On 02/23/2026 at 3:08 PM, Resident #5's clinical record was reviewed for evidence of written notice of transfer and documentation that the resident and/or representative had been informed of the facility's bed-hold policy. No documentation of a notice of transfer or bed-hold policy disclosure was found in the medical record.On 02/24/2026 at 8:55 AM, an interview was conducted with the Director of Nursing (DON) regarding the facility's process for hospital transfers and discharges. The DON stated that when a resident is transferred to the hospital, the facility obtains a physician order, completes e-Interact/SBAR documentation, and notifies the family. When asked about the expectation for providing notice of transfer and bed-hold policy information, the DON stated that a bed hold is completed for every hospital transfer and that the family is notified.On 02/24/2026 at 8:57 AM, the DON was requested to provide documentation demonstrating that notice of transfer and bed-hold policy information had been provided for Residents #5 and documentation demonstrating that notice of transfer for Resident #14.On 02/24/2026 at 9:54 AM, the DON returned and stated that there was no documentation of the notice of transfer or the bed-hold policy for Resident #5 and notice of transfer for Resident #14. The DON further stated there was no other documentation available to demonstrate that the required notification had been provided. When asked whether the notice of transfer and bed-hold policy should have been provided, the DON stated that it is the facility's policy to notify the resident and/or family of the transfer and to offer the bed-hold policy. When informed that the lack of documentation was a concern, the DON acknowledged the concern.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, record reviews, and interviews it was determined that the facility failed to develop and/or update the comprehensive care plan to include oxygen therapy. This was evident for 1 (Resident #2) out of 5 residents observed for respiratory care during the annual survey. A care plan is a simple written plan that explains how to take care of a resident's health and daily needs. It lists what the resident needs help with, what their goals are, and what caregivers should do to help them. It makes sure everyone helping the resident knows the same plan so the care stays organized and consistent. The findings include: On 02/19/2026 at 8:21 AM, an observation of Resident #2 revealed that the resident was receiving oxygen therapy. On 02/19/2026 at 10:13 AM, record review revealed Resident #2 had an active physician's order for oxygen. Further review of the comprehensive care plan revealed no goals, or interventions addressing oxygen therapy, including administrations, monitoring or safety precautions. On 02/24/2026 at 8:58 AM, an interview with the Director of Nursing revealed that the expectation was that residents receiving oxygen therapy had this addressed in the comprehensive care plan. On 02/24/2026 at 9:03 AM, the concern was addressed with the Director of Nursing, and she indicated that she understood.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interviews, it was determined that the facility failed to accurately and completely document a resident's pain as ordered by the physician. This was evident for 1 (Resident #119) of 1 resident reviewed for pain management. The findings include: On 02/24/2026 at 9:29 AM, a review of the resident #119's medical records revealed an order that stated, Has the elder experienced pain during the last 8 hours. If yes, complete a progress note. On 02/24/2026 at 9:45 AM, a review of the resident's treatment administration record (TAR) for January and February of 2026 revealed an assessment task that stated Has the elder experienced pain during the last 8 hours. If yes, complete a progress note. The task documentation revealed several assessments that indicated the resident had pain. On 02/24/2026 at 10:04 AM, a review of the resident's progress notes failed to reveal any documentation related to the resident's pain assessment. On 02/24/2026 at 10:25 AM, during an interview with the Director of Nursing (DON), she stated that her expectation of the nursing staff was to assess the resident for pain and then to document the pain assessment in a progress note per the physician's order. At this time the surveyor asked the DON to provide proof of the pain progress notes. On 02/24/2026 at 10:42 AM, during a follow up interview with the DON. She stated that she was not able to locate any pain progress notes. She then stated that there should be progress notes related to the resident's pain assessment because the order stated to do so. At this time she was made aware of the concern of missing pain assessment documentation and not following the physician's orders.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, record reviews, and interviews with facility staff, it was determined that the facility failed to ensure residents were served meals according to the predetermined menu that incorporated resident preferences. This was evident for three residents (Residents #2, #63, and #163) out of four residents reviewed for concerns related to the food menu during the facility's recertification survey. The findings include:On 02/19/2026 at 8:14 AM, during the initial tour of the facility, Resident #2 stated that the meal served did not match the meal ticket. The surveyor observed a hard-boiled egg, a piece of ham, and bread on the resident's plate. The resident's meal ticket indicated juice, oatmeal, scrambled eggs, bacon, cranberry orange muffin, fruit, milk, and coffee.On 02/19/2026 at 8:40 AM, during the continued tour, Resident #63 stated that he/she was not receiving pre-ordered meals due to unavailability of the meals ordered. When asked how long this had been occurring, the resident stated it had been for a while.On 02/20/2026 at 7:20 AM, a review of the day's lunch menu indicated the main entree as potato-crusted fish with rice pilaf, seasoned greens, roll with margarine, and chocolate cake with frosting. The alternate entree was Salisbury steak with gravy, mashed potatoes with gravy, and Italian blend vegetables.On 02/20/2026 at 12:32 PM, during a follow-up interview with Resident #63, the surveyor observed mashed potatoes, carrots, peas, and a bread roll on the resident's plate. When asked whether this was the preferred meal, the resident stated he/she had requested rice pilaf as listed on the menu, but mashed potatoes were served, which were part of the alternate entree. The resident also stated that cake with frosting was not served. When asked for the meal ticket, the resident stated it could not be located.On 02/20/2026 at 1:07 PM, during a follow-up interview with Resident #2, the resident stated that an alternate meal tray consisting of Salisbury steak with gravy, mashed potatoes with gravy, and vegetables had been provided. The resident stated a preference not to have gravy; therefore, the meal tray was returned.On 02/24/2026 at 11:36 AM, during a dining observation, the surveyor observed Resident #163 with a regular potato, cornbread, carrots, peas, peanut butter pie, and a beverage on the table. When asked whether the preferred meal was received, the resident stated it was a regular potato rather than the baked sweet potato listed and added that he/she would eat it. The resident provided the meal ticket, which indicated cola-glazed ham, baked sweet potato, Italian blend vegetables, cornbread with margarine, peanut butter pie, and a beverage.On 02/24/2026 at 12:54 PM, during an interview with the Certified Dietary Manager (CDM), when asked if residents meal preferences were followed, he stated that residents were supposed to receive what was listed on the menu or according to their meal preferences which the facility followed. When informed that a resident reported the menu listed baked sweet potatoes, but a regular potato was served instead, the CDM stated sweet potatoes were available but remained in the oven at lunchtime; therefore, regular potatoes were served. When asked whether residents were informed of the delay and offered a choice, he stated they were not informed and acknowledged they should have been notified of the delay and offered an alternative option rather than being served what was available.On 02/25/2026 at 12:49 PM, the concern was presented to the Nursing Home Administrator (NHA), the Director of Nursing (DON) and they acknowledged the concern.