STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215084	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patapsco Healthcare	9109 Liberty Road Randallstown, MD 21133

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure: 1. & 2 .) medical record documentation from outside consult providers was present within the medical record. This was evident for: 1.) 1 out of 1 Resident (#55) reviewed for urinary catheter and 2.) 1 out of 1 Resident reviewed for Neglect (#134) and during the surveyor's review of Complaint #2694340 during the facility's recertification survey.The findings include: Based on observation, interview and record review and review of Complaint #2694340 it was determined the facility failed to: 1) maintain medical records in accordance with accepted professional standards and practices. This was evident for 7 (Resident #5, #23, #7, #99, #115, #61, and #125) out of 57 residents reviewed; 2) ensure that a hospital transfer form document contained current and accurate documentation. This was found to be evident for 1 (Resident # 11) of 3 residents reviewed for hospitalizations; 3) ensure medical record documentation from outside consult providers was present within the medical record. This was evident for 1 out of 1 Resident (#55) reviewed for urinary catheter and 1 out of 1 Resident reviewed for Neglect (#134) during the facility's annual survey. The findings include: 1. On [DATE] at 2:00PM, a review of the facility's Smoker's List as of [DATE] revealed that Residents #99, #115, #61, and #125 were independent smokers. The facility completed Safe Smoker Assessment quarterly and as needed for Resident's who are smokers. On [DATE] at 8:10AM, during a review of Resident #99's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE] and was a smoker prior to admission. A smoking contract was completed on admission. Further review failed to reveal a Safe Smoker Assessment completed at the time of admission. On [DATE] at 8:27AM, during a review of Resident #115's electronic medical record, the Surveyor discovered that the facility failed to complete a quarterly Engage Safe Smoker Assessment between the assessment on [DATE] and [DATE]. On [DATE] at 9:10AM, during a review of Resident #61's electronic medical record, the Surveyor discovered that the facility failed to complete a quarterly Engage Safe Smoker Assessment between [DATE] and [DATE], and [DATE] and [DATE]. On [DATE] at 9:35AM, during a review of Resident #125's electronic medical record, the Surveyor discovered that the facility failed to complete quarterly Engage Safe Smoker Assessments between [DATE] and [DATE]. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted with the Director of Nursing on [DATE] at 10:00AM, the Surveyor expressed the concern that Resident #99, #115, #61, and #125 were identified as independent smokers according to the facility's smokers list and had missing quarterly Engage Safe Smoker Assessments. The DON confirmed that Safe Smoking Assessments should be completed quarterly and as needed for residents who smoke. 2. On [DATE] at 1:31PM, during a review of Resident #5's electronic medical record, the Surveyor discovered the resident had a history of falls. A review of the residents Fall Risk Evaluation completed on [DATE], indicated the resident was a low fall risk with a score of 3; however, the fall assessment was incomplete and failed to include medications used and gait analysis. A review of a Fall Risk Evaluation completed on [DATE], indicated the resident was a low fall risk with a score of 4; however, the fall assessment was incomplete and failed to include all medications used and gait analysis. A review of a Fall Risk Evaluation completed on [DATE], indicated the resident was a low fall risk with a score of 5; however, the fall assessment was incomplete and did not include medications used and gait analysis. 3. Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. Cardiopulmonary resuscitation (CPR) is a lifesaving technique used in emergencies in which someone's breathing or heartbeat has stopped. Full code. Do Not Intubate (DNI) is an order placed in a person's medical record by a doctor informs the medical staff that chest compressions and cardiac drugs may be used, but no breathing tube will be placed. On [DATE] at 10:20AM, during a review of Resident #5's paper chart, the Surveyor discovered a MOLST form dated [DATE]. According to the MOLST form, within Option A, prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally. Option A-2, Do Not Intubate (DNI) was selected. Further review revealed another MOLST form dated [DATE]. According to this MOLST form, attempt CPR was selected. On [DATE] at 11:00AM, a review of Resident #5's electronic medical record revealed an active physician's order for full code and an uploaded copy of the MOLST dated [DATE] which stated to attempt CPR. On [DATE] at 11:50PM, during an interview conducted with Unit Manager (UM)#13, the Surveyor confirmed that Resident #5 had a MOLST form dated [DATE] indicating DNI and a MOLST form dated [DATE] indicating attempt CPR within the resident's paper chart. During a review of Resident #5's electronic medical record, UM #13 and the Surveyor confirmed that the resident had a physician's order for full code and an uploaded copy of the MOLST form dated [DATE] indicating full code. The Surveyor asked the UM #13 to confirm the resident's code status. UM #13 stated they would review the resident's medical record and the physician for clarification. On [DATE] at 12:49PM, the Surveyor informed the Director of Nursing (DON) and the Regional Director of Clinical Operations of their findings in Resident #5's paper and electronic medical record. The DON stated that the resident was a DNI code status and that Full code was documented in the resident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical record in error. The Surveyor asked the DON to verify the code status with the resident/resident representative and the physician to ensure the correct code status was placed in the medical record. On [DATE] at 3:00PM, a review of Resident #5's electronic medical record revealed a new physician order for DNI. The DON confirmed the resident code status with the physician who completed the MOLST dated [DATE] indicating DNI code status. On [DATE] at 2:50PM, the DON provided the Surveyor with a copy of the Medical Provider Visit note where the resident's code status was reviewed with the resident and the resident representative. On [DATE] at 11:00AM, during a review of Resident #5's electronic medical record, the Surveyor reviewed the Engage Care Conference Meeting dated [DATE] which documented the resident as a Full Code. A review of the Dialysis Services Communication Forms reviewed from [DATE] through [DATE] revealed that the nursing staff did not complete, in full, the Pre-Treatment Report/SNF Nurse section on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Further review of [Dialysis Company] SNF Dialysis Service Communication Forms, the Pre-Treatment Report/SNF Nurse section to be completed by nursing staff, on [DATE],[DATE], and [DATE] the code status checked was Full Code and on [DATE], [DATE], and on [DATE] the code status was DNI. On [DATE] at 9:00AM, during an interview conducted with the DON, the Surveyor expressed the concern that due to inaccurate documentation of Resident #5's code status in the medical record, the Resident's code status was inaccurately documented on a care conference meeting note on [DATE] and in the Pre-Treatment Report/SNF Nurse section of the Dialysis Services Communication Forms from [DATE] through [DATE]. The Surveyor also expressed the concern that the Dialysis Services Communication Forms were not completed in full by nursing staff. The DON stated that they would review the resident's medical record and provide staff education for completing the Pre-Treatment Report/SNF Nurse section of the Dialysis Services Communication Form prior to the resident going to dialysis. 4. Physician certification of incapacity requires written documentation. Personal examination-based evaluation determines a resident's decision-making capacity due to physical or mental health issues and requires 2 qualified professionals, often the attending physician and a second physician. On [DATE] at 10:30AM, during paper chart review on the Liberty Hall Unit, the Surveyor discovered Resident #23 had Physician Certifications completed on [DATE], [DATE], and [DATE] determining the resident lacks adequate decision-making capacity (including decisions about life sustaining treatments) with only one physician signature. During continued paper chart review, the Surveyor discovered Resident #7 had a Physician Certification completed on [DATE] determining the resident lacks adequate decision-making capacity (including decisions about life sustaining treatments) with only one physician signature. On [DATE] at 1:00PM, during an interview with the DON on the Liberty Hall Unit, the Surveyor expressed the concern that Resident #23 had Physician Certifications completed on [DATE], [DATE], and [DATE] with only one physician signature and Resident #7 had a Physician Certification completed on [DATE] with only one physician signature. The DON and the Surveyor reviewed the documentation, and the DON confirmed the Surveyor's findings. The DON stated that the facility will ensure the physicians address the residents' Physician Certifications and the staff will be completing audits for Physician Certification. (continued on next page)

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