STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215088	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammonds Lane Center	613 Hammonds Lane Brooklyn Park, MD 21225

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 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 record review and interviews with resident and staff, it was determined that the facility failed to maintain accurate medical records in accordance with accepted professional standard and practices. This was evident for 11 (Resident #11, #23, #33, #34, #41, #13, #27, #72, #84, #5, and #97) residents out of 68 residents reviewed during the annual survey.The findings include: Bedrails, also known as side rails, are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them, such as suffocation, entrapment, and psychological risks. A Resident or Resident's Representative should be provided with the risks and benefits along with a signed consent obtained before the use of bedrails. 1. On [DATE] at 11:18AM, during an interview with Resident #11, the Surveyor observed the resident lying in bed with the head of the bed at about 30 degrees. There were quarter size bed rails raised on both sides at the top of the bed. The resident stated that the bed rails assist them with bed mobility. On [DATE] at 12:25PM, during rounds on the A wing nursing unit, the Surveyor observed Resident #11 lying in bed with the head of the bed at about 30 degrees. The quarter size bed rails were raised on both sides at the top of the bed. On [DATE] at 11:35AM, a review of Resident #11’s electronic medical record revealed a Bed Safety Evaluation dated [DATE] and a Bed Safety Evaluation Follow-up dated [DATE], with quarter size bed rails recommended on both sides of the bed for mobility. The final action for bed rail use was to obtain consent and obtain a physician’s order. Further review failed to reveal resident or resident representative consent nor a physician’s order for bed rail use. 2. On [DATE] at 11:34AM, the Surveyor observed Resident #34 sitting on the right side of their bed with their feet touching the ground. The resident was using the right quarter bed rail to hold themselves upright with the left hand. On [DATE] at 8:30AM, during an interview with Resident #34, the Surveyor observed the resident lying flat in bed with both quarter bed rails raised at the top of the bed. The resident used the bed rail to adjust themselves in bed. (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	On [DATE] at 11:45AM, a review of Resident #34’s electronic medical record revealed a Bed Safety Evaluation dated [DATE] and a Bed Safety Evaluation Follow-up dated [DATE], with quarter size bed rails recommended on both sides of the bed for mobility. The final action for bed rail use was to obtain consent and obtain a physician’s order. Further review failed to reveal resident or resident representative consent nor a physician’s order for bed rail use. During an interview with the Director of Nursing (DON) on [DATE] at 12:20PM, the Surveyor was informed that Resident #11 and Resident #34 use the quarter bed rails for mobility. The facility only uses the quarter bed rails at the top of the bed. Any resident who uses bed rails should have a Bed Safety Evaluation and Bed Safety Evaluation Follow-up (if recommended to use bed rails) completed on admission or whenever initiating the use of bed rails. Resident or resident representative consent and a physician’s order is obtained prior to use. The Surveyor expressed the concern that Resident #11 nor Resident #34 had an order for the use of side rails and resident or resident representative consent in their electronic medical record and requested that documentation. On [DATE] at 2:30PM, the DON and Surveyor confirmed that Resident #11and Resident #34 had signed consent, however failed to have a physician orders for the use of quarter bed rails. The DON conducted a house-wide audit, and new orders for Resident #11 and Resident #34 were received. 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. Do Not Resuscitate (DNR) is an order placed in a person’s medical record by a doctor informs the medical staff that CPR should not be attempted. 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. 3. On [DATE] at 11:49AM, the Surveyor reviewed a MOLST form. 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. There is option A-1, allowing intubation and option A-2, Do Not Intubate (DNI). A review of Resident #23’s current MOLST form dated [DATE], indicated that the resident requests No CPR option A-1, which states that comprehensive efforts may include intubation and artificial ventilation. On [DATE] at 10:45AM, a review of Resident #23’s electronic medical record revealed a physician’s order for DNR. Additional review of the resident’s electronic medical record revealed a Social Services Assessment and Documentation form completed on [DATE]. Within Section 5g., Resident Rights/Healthcare Decision Making/Advanced Directives, it is noted that “per resident request the following orders are in place: DNR/DNI. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:05PM, during an interview with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #23’s MOLST indicated that the resident was No CPR (DNR) Option A-1 allowing intubation and the Social Services Assessment Documentation indicated the resident was DNR/DNI, not allowing intubation. The DON stated she would review the concern with Social Service Director #3. On [DATE] at 1:30PM, during an interview with the Social Service Director #3, the Surveyor was informed that Resident #23 is No CPR (DNR) Option A-1, allowing intubation. Social Services Director #3 stated that the information in the Social Services Assessment and Documentation form, Section 5g., completed on [DATE], was incorrect and will provide education to the staff member who completed the document. The document was updated to reflect the resident’s current code status. Preadmission Screening and Resident Review (PASRR) is a federal program that screens individuals applying to or reside in Medicaid-certified nursing facilities for serious mental illness (SMI) or intellectual disability (ID). The purpose is to ensure these individuals receive the most appropriate and least restrictive care setting and services. 4. On [DATE] at 9:30AM, during a review of Resident #11’s electronic medical record, the Surveyor discovered that the resident had diagnoses of, but not limited to, schizoaffective disorder, bipolar type, major depressive disorder, and vascular dementia without behavioral, psychotic, or mood disturbance, and anxiety. On [DATE] at 11:23AM, during a review of Resident #11’s PASRR dated [DATE], the Surveyor noted that Section C1: Diagnosis. Does the individual have a major mental disorder? “No” was checked off. On [DATE] at 12:00PM, during an interview with Social Services Director #3, the Surveyor was informed that examples of diagnoses that would indicate major mental disorder would include schizophrenia, bipolar disorder, major depression, and anxiety disorder. The Surveyor expressed the concern that Resident #11’s current PASRR did not reflect his/her current mental health diagnoses. According to the resident’s diagnosis information, in their electronic medical record, the resident was diagnosed with major depressive disorder [DATE], depression [DATE], and schizoaffective disorder, bipolar type [DATE]. Social Service Director #3 stated that at the time the initial PASRR was completed, Resident #11 was not diagnosed with a major mental disorder. The Surveyor and the Social Services Director #3 confirmed the resident’s current diagnosis, and determined that the resident should have had a new PASRR completed to reflect the resident’s current mental health status to ensure he/she receives the appropriate care. Social Services Director #3 stated that she would review Resident #11’s medical record to see if he/she has a updated PASRR. On [DATE] at 1:30PM, Social Services Director #3 informed the Surveyor that she was unable to locate an updated PASRR which included current diagnoses of major depression and schizoaffective disorder, bipolar type. Social Services Director #3 stated that she would complete a new PASRR for Resident #11. On [DATE] at 3:39PM, Social Services Director #3 provided the Surveyor with a updated copy of Resident #11’s PASRR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On [DATE] at 9:05AM, the Director of Nursing (DON) provided the Surveyors with a copy of the facility’s current list of independent smokers. The DON stated that residents on the list were able to smoke independently. Resident #33 was on the current list as an independent smoker. On [DATE] at 1:00PM the DON provided the Surveyors with an updated independent smoking list. The DON stated that residents on the list were able to smoke independently. Resident #33 was on the current list as an independent smoker. During a review of Resident #33’s electronic medical record on [DATE] at 1:45PM, the Surveyor discovered a current Smoking Evaluation completed on [DATE] which indicated the resident needed to be supervised while smoking and a note that states the “patient attempts to keep [his/her] liter on person. ” On [DATE] at 3:05PM, the DON provided the Surveyors with an updated independent smoking list. The DON stated that residents on the list were able to smoke independently. Resident #33 was on the current list as an independent smoker. On [DATE] at 10:15AM, a review of Resident #33’s electronic medical record revealed the same Smoking Evaluation completed on [DATE] which indicated the resident needed to be supervised while smoking and a note that states the “patient attempts to keep [his/her] liter on person.” During an interview with the DON on [DATE] at 10:45AM, the Surveyor expressed the concern that Resident #33 had a current Smoking Evaluation completed on [DATE] which indicated the resident needed to be supervised while smoking and that the current smoking list provided on [DATE] at 3:05PM, listed the resident as an independent smoker. The DON stated that the resident only smokes when family comes in and takes him/her outside to smoke. The Surveyor asked, “Does this resident need to be supervised while smoking?” The DON stated she would get back to the Surveyor. On [DATE] at 3:00PM, the DON provided the Surveyors with a copy of the updated smoking list. Resident #33 was listed as a supervised smoking resident who only smokes with family. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident’s functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. 6. On [DATE] at 11:00AM, a review of Resident #41’s electronic medical record revealed that the resident had diagnoses of, but not limited to, contracture of the left hand, muscle weakness, abnormalities of gait and mobility, functional quadriplegia, and dementia. On [DATE] at 11:21AM, during a review of Resident #41’s electronic medical record, the Surveyor discovered an Annual MDS assessment from [DATE]. Section GG identifies the resident’s functional abilities. According to Section GG, Resident #41 has impairment to one side of the upper extremity, no impairment of the bilateral lower extremity, uses a wheel chair, was dependent with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The resident was dependent with roll left and right, sit to lying, lying to sitting on the side of the bed, independent with sit to stand, setup or clean up assistance with chair/bed to chair transfer, and substantial/maximal assistance with toilet transfer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:47 AM, the surveyor interviewed staff #2. During the interview, the surveyor made staff #2 aware that Resident #27’s Smoking Evaluation (SNF) - V 4 and care plan do not indicate that Resident #27 can smoke independently. Staff #2 stated that she will update the facility’s smoker list. 9. On [DATE] at 9:05 AM, the facility's records were reviewed. The facility record review revealed that Resident #72 was listed on the facility’s smoker list. On [DATE] at 9:06 AM, the surveyor interviewed staff #2. During the interview, staff #2 stated that all smokers listed on the facility's smoker list can smoke independently. On [DATE] at 1:45 PM, Resident #72’s medical records were reviewed. The medical record review revealed that Resident #72 did not have a Smoking Evaluation (SNF) - V 4 documented. On [DATE] at 1:52 PM, Resident #72's medical record was reviewed. The medical record review revealed that Resident #72 was not care planned for smoking. On [DATE] at 11:48 AM, the surveyor interviewed staff #2. During the interview, the surveyor made staff #2 aware that Resident #72 does not have a Smoking Evaluation (SNF) - V 4 documented, and Resident #72 was not care planned for smoking. On [DATE] at 3:06 PM, the surveyor interviewed staff #2. During the interview, staff #2 stated that Resident #72 no longer smokes. Staff #2 also stated that she will update the facility’s smoker list. 9. On [DATE] at 9:05 AM, the facility's records were reviewed. The facility record review revealed that Resident #84 was listed on the facility’s smoker list. On [DATE] at 9:06 AM, the surveyor interviewed staff #2. During the interview, staff #2 stated that all smokers listed on the facility's smoker list can smoke independently. On [DATE] at 1:48 PM, Resident #84’s medical records were reviewed. The medical record review revealed that Resident #84’s Smoking Evaluation (SNF) - V 4, dated [DATE], in 1. Smoking decision under E. Evaluation states that Supervised smoking is required. Also, “1a. Reason/Additional Comments” of E. Evaluation states “to be supervised at all time[s]”. On [DATE] at 1:51 PM, Resident #84's medical record was reviewed. The medical record review revealed that the resident’s care plan stated Patient may not smoke cigarette per smoking evaluation. On [DATE] at 3:16 PM, the surveyor interviewed staff #2. During the interview, the surveyor made staff #2 aware that Resident #84’s Smoking Evaluation (SNF) - V 4 does not indicate that Resident #84 was an independent smoker, and that Resident #84’s care plan stated Patient may not smoke cigarette per smoking evaluation. Staff #2 stated that she will review Resident #84’s care plan. On [DATE] at 9:41 AM, the surveyor interviewed staff #2. During the interview, staff #2 stated that she will update Resident #84’s Smoking Evaluation(SNF) - V 4 and care plan to reflect Resident #84 as an independent smoker. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of Resident #5's medical record on [DATE] at 08:00 AM revealed a Medication Administration Record (MAR) for the month of [DATE] with a physician order dated [DATE]; Is resident free from side effects of psychotherapeutic medications? (If no, document side effects in PN) every shift for Monitoring. Further review of the MAR revealed that staff documented “No” on [DATE] on evening and night shift. On 08/02, 08/03, 08/04, 08/05, 08/06, 08/07, 08/08, 08/09, 08/10, 08/11, 08/12, 08/13, 08/14, 08/15, 08/16, [DATE] on day, evening and night shift, there were no progress notes (PN) documenting the side effects that were found. During an interview on [DATE] at 10:00 AM the Director of Nursing stated “that the letters (PN) noted on Resident #5's order dated [DATE]; Is resident free from side effects of psychotherapeutic medications? (If no, document side effects in PN) every shift for Monitoring, means to document side effects in Resident #5's medical record under Progress Notes (PN), there were no progress notes completed for staff members who documented no, staff should have completed a progress note and or the staff are documenting incorrectly”. 11. During observation rounds and interview on [DATE] at approximately 8:10 AM, Resident #97 was found in his/her room holding a green and white in color pack of cigarettes as well as a blue lighter. Resident #97 stated that, “Yes I smoke, and these items belong to me”. On [DATE] at 9:05 AM a list of facility smokers was provided to the survey team by the facility and revealed that Resident #97 was not listed as a smoker. During an interview on [DATE] at 1:00 PM the Director of Nursing staff #2 (DON) brought an updated list of residents that smoke and stated, “Resident #97 should have been on the list of facility smokers because Resident #97 smokes”. Review of updated list of facility smokers at [DATE] at 1:00 PM revealed that resident #97 was added to the list.