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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215154 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/01/2025 |
| NAME OF PROVIDER OR SUPPLIER Roland Park Place | | STREET ADDRESS, CITY, STATE, ZIP CODE 830 West 40 Street Baltimore, MD 21211 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>Based on resident interview, record review, and staff interview, it was determined that the facility failed to notify the ombudsman of a resident's transfer to the hospital. This was evident for 1 (Resident #8) out of 1 resident reviewed for hospitalizations.</p> <p>The findings include:</p> <p>On 4/29/25 at 9:44 AM, an interview was conducted with Resident #8. When asked whether they were hospitalized recently, Resident #8 stated that they had just returned from the hospital a few days ago.</p> <p>On 4/29/25 at 1:02 PM, a review of Resident #8's progress notes was conducted. In the note from 4/18/25 at 2:44 pm, it was documented that the resident was transferred to the hospital for further evaluation of shortness of breath.</p> <p>On 4/29/25 at 2:20 PM, an interview with the Nursing Home Administrator (NHA) was conducted. When asked to provide evidence that the ombudsman was notified of Resident #8's transfer on 4/18/25, the NHA stated that they were unaware that the ombudsman needed to be notified of resident transfers to hospital. This surveyor made the NHA aware that notifying the ombudsman of transfers and discharges is a federal and state regulation.</p> <p>On 4/30/25 at 10:45 AM, an interview with the NHA was conducted. The NHA stated that they now have a plan in place to notify ombudsman of transfers to hospitals and have notified the ombudsman of Resident #8's transfer to the hospital after surveyor intervention.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>Based on resident interview, record review, and staff interview, it was determined that the facility failed to provide the bed-hold policy to a resident or resident representative before the resident was transferred to the hospital. This was evident for 1 (Resident #8) out of 1 resident reviewed for hospitalizations.</p> <p>A bed-hold policy addresses holding a resident's bed during periods of absence, such as during hospitalization or therapeutic leave.</p> <p>The findings include:</p> <p>On 4/29/25 at 9:44 AM, an interview was conducted with Resident #8. When asked whether they were hospitalized recently, Resident #8 stated that they had just returned from the hospital a few days ago.</p> <p>On 4/29/25 at 1:02 PM, a review of Resident #8's progress notes was conducted. In the note from 4/18/25 at 2:44 pm, it was documented that the resident was transferred to the hospital for further evaluation of shortness of breath.</p> <p>On 4/29/25 at 2:20 PM, an interview with the Nursing Home Administrator (NHA) was conducted. The NHA stated that they would check if a bed-hold policy was provided to Resident #8.</p> <p>On 4/30/25 at 10:45 AM, an interview with the NHA was conducted. The NHA confirmed that a bed-hold policy was not provided to Resident #8 or their Representative. The NHA stated that they were not aware that a bed-hold policy needed to be provided to the resident or resident representative.</p> |